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RURAL HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION AND BUSINESS OPPORTUNITIES

OF THE

COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

BAKER, OR, AUGUST 18, 1988

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RURAL HEALTH CARE

THURSDAY, AUGUST 18, 1988

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION AND
BUSINESS OPPORTUNITIES,
COMMITTEE ON SMALL BUSINESS,
Baker, OR.

The subcommittee met, pursuant to notice, at 9 a.m., in the Circuit Courtroom, Baker County Courthouse, 1995 Third Street, Baker, OR, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The Subcommittee on Regulation and Business Opportunities will come to order.

I am very pleased to be able to be here and join all of you today for this very important hearing.

The Subcommittee on Regulation and Business Opportunities is convened today to assess the quality, accessibility, and affordability of health care in our rural communities.

The evidence indicates that there is more than one drought in rural areas. In some communities the right of access to health care is also evaporating.

There are several powerful forces that are driving this trend. One is the lack of providers such as physicians, home health providers, social workers, physician assistants, and nurses.

In rural areas it is difficult to attract more talented professionals and we will find out why from our witnesses today.

There are several efforts underway in the Congress to reverse this trend. I have introduced legislation that I think will pass in this session of the Congress to address the critical shortage of nurses by providing additional Federal assistance to train and educate more nurses and to look at ways to have a long-term program for keeping good nurses in the profession.

I have also recently introduced legislation to give social workers direct Medicare reimbursement in rural health clinics.

Another serious problem is that the Federal Government, specifically the Medicare program has dealt rural communities a crooked hand. The Federal Government decided to reimburse rural health care providers less than their counterparts in the city because it calculated that it costs less to provide health care in rural areas than it does in the city.

Unfortunately, the Federal Government calculated wrong. As so many in this room are painfully aware, providing rural health care costs as much or more than in the city. The vast areas that must be covered and rural America's growing elderly population and

their special health care needs combine to create unique and expensive demands on rural health care providers.

Now it is my view that the cumulative effect of these forces can blow through a rural community like a heavy storm. Providers will not come to communities without adequately financed facilities. Without hospitals and clinics businesses will not expand or move in. Without business growth and employment small communities will wither and die.

It is high time the Federal Government recognized the special predicament of rural communities struggling to provide health care for their citizens.

I intend to use the record that we develop today to push for more Medicare reimbursement for rural health care providers. There needs to be more support for legislation that expands the role of nurses, physician assistants, social workers, and other health professionals who together can expand a range of health services in rural America.

I believe there also needs to be support for the area health education center program which would provide opportunities for students to experience rural health care first hand.

Today we are going to listen to testimony from providers who are suffering from the reimbursement disparity and from community leaders who have seen economic development suffer because of the broad scope of the health care problem in rural America.

Oregon, this innovative leader in health care areas, has implemented some creative solutions. We are going to receive testimony from some of those individuals and hear about how we can build on some of the innovative approaches being undertaken in our State.

I am very pleased that our witnesses have taken time from their schedules and traveled long distances in some instances. We are going to begin with an overview of the problem by Ms. Marsha Kilgore, manager of the Office of Rural Health and president of the National Rural Health Association.

Marsha, you have been most helpful in working on this issue. We know of the Governor's very strong interest and commitment to this special area of concern. We are going to make a copy of your statement a part of the record in its entirety and if you could perhaps summarize your principal concerns, that would be helpful.

Let me tell all of our witnesses, I know that there is always a powerful temptation to read every word in your statement. We will make your statements a part of the record in their entirety and if you could perhaps summarize your principal concerns in five minutes that would be very helpful because we have a long panel of witnesses today.

So, Ms. Kilgore, we welcome you. Let us make sure that you have that microphone, I think it is the one there on the left, in front of you so that everyone else in addition to myself can hear and if you can speak and get real close to it, that would be helpful.

TESTIMONY OF MARSHA KILGORE, MANAGER, OFFICE OF RURAL HEALTH, AND PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Ms. KILGORE. Good morning.

My testimony this morning is intended to set the stage for what you are about to hear over the next couple of hours.

I would like to highlight my comments in two parts. First of all I will describe some of the major rural health issues and problems occurring throughout the Nation and second I will briefly describe some of the rural health problems and issues here in Oregon and share with you some of the strategies now being developed to address some of these problems.

I would like to begin by referring you to the attached report, "Health Care in Rural America: The Crisis Unfolds" recently commissioned by the Nation's two leading groups concerned with health care in rural America, the National Rural Health Association and the National Association of Community Health Centers. For the sake of time, let me summarize the findings and recommendations outlined in that report.

There is no question that we are facing a deteriorating rural health care, worsened by the failing farm economy. There is a critical need for health services, hospitals, physicians, and nurses, all problems which have been exacerbated by the steady decrease in their availability.

The high rate of infant mortality is an example of the poor state of health care in rural America. The United States as a nation has declined from sixth to a tie for the last place among 20 industrialized nations in combating infant mortality, and within this country, rural Americans have rates higher than their white and minority counterparts in urban areas. The problem is further exacerbated by the malpractice insurance crisis that is forcing family practice physicians out of obstetrical services.

The health plight of migrant workers is also discussed in the report. They are described as an "outsider" group moving from community to community, always far from family and social support groups. To quote the report, "Their outsider status places them at the bottom of the priority pyramid when services are available and keeps them finding system access points which are well understood even by long-term residents."

Additionally, the report concludes that the health care systems of rural America are inadequate to serve the needs of those who depend on them. Particular problems cited include:

(1) 75 percent of the rural poor do not qualify for public assistance.

(2) The lack of comprehensive prenatal care combined with problems of poverty in rural areas has led to high rates of infant mortality, particularly for Blacks who face a 25-percent increase over their counterparts in urban areas.

(3) Rural residents have a 15-percent higher rate of uninsuredness than the U.S. average and a 25-percent higher rate than their metropolitan counterparts. This leads to a cash drain on the rural family; rural residents pay, on the average, 10 percent more of their income out-of-pocket for health care than their urban counterparts.

(4) At a time when rural needs for physicians are high, the National Health Corps, an important source of physicians for rural areas, is being dismantled.

(5) Rural hospitals are closing at a record-setting pace.

(6) Systems of reimbursement and insurance are geared to high volume areas, often making the cost of providing services to rural areas too burdensome for physicians and hospitals.

(7) The nationwide nursing crisis and malpractice insurance crisis are hitting rural areas particularly hard, often leading to the inability of access entry level care.

A few recommendations cited in the report to address some of these critical problems include:

(1) Reform of health manpower programs and State statutes to more effectively recruit, retain, and utilize health care professionals in rural areas.

(2) Full funding of programs like the Community/Migrant Health Center and National Health Service Corps programs to assure the availability of health care and providers in our rural areas.

(3) Revision and full implementation of Government reimbursement policies to provide equity to rural hospitals, to increase participation in the Rural Health Clinic Act to foster incentives to attract health care providers to rural areas.

(4) Pursuit of public/private initiatives designed to enhance health insurance coverage for the growing number of Americans without health coverage.

(5) Development of model legislation and strategies to encourage States to address the malpractice insurance crisis and its negative impact on access to obstetrical services and infant mortality.

(6) Development of programs for rural areas to address public health problems such as AIDS, infant mortality, and homelessness.

(7) And a final recommendation, to continue the current efforts for conducting practical research to assure a solid understanding of the nature and extent of rural health care problems.

Let me now turn to the rural health issue and problems in Oregon which are not at all dissimilar to the rest of rural America.

First of all a few facts to set the stage:

(1) 50 percent of the total State population is living in rural areas.

(2) 11 of our 36 counties meet the definition as "frontier" counties meaning those that are less than six people per square mile.

(3) 125,000 Oregonians live in 39 designated Rural Health Manpower Shortage Areas.

(4) An additional 115,000 migrant and seasonal farm workers are without adequate access to health care.

(5) 36 or almost half of Oregon's hospitals are classified as rural.

(6) 8 of the 36 rural hospitals, also referred to as "essential" rural hospitals have less than 50 licensed beds and are between 44 and 96 miles to the nearest hospital.

(7) 25 rural nonprofit public or private primary health care clinics exist in the State, of which 17 are solely operated by nurse practitioners or physician assistants.

The number one problem facing rural hospitals and clinics in this State is the ability to recruit and retain health care professionals. That includes physicians, nurses, nurse practitioners, physician assistants, and other allied health professionals. Other major issues and problems, which others today will provide you with more detail, include:

(1) A decreasing lack of obstetrical services and inadequate prenatal care.

(2) Increasing elderly populations.

(3) Increasing number of individuals without health insurance and who do not qualify for Medicare or Medicaid.

(4) Inequity in Medicare reimbursement to rural hospitals and rural physicians.

(5) Lack of access to capital for renovation, remodeling, or construction of old and outdated medical facilities.

(6) Lack of sufficient resources to support adequate administration and management of health care service.

(7) In general, an overall decline in rural economy here in this State.

Some of the strategies we, here in Oregon, are implementing or are in the development stages for addressing these problems include:

(1) Continued support for the State Office of Rural Health with a focus on providing technical assistance and consultation to primary health care clinics and rural hospitals, including a formal recruitment and retention program for health professionals.

(2) Increasing our efforts to promote linkage, networks, and coordination among the variety of health care services in rural areas to further the development of health care delivery systems.

(3) Continued support of the utilization of nurse practitioners and physician assistants.

(4) Support for the Oregon Health Sciences University to establish a Rural Family Practice Residency Program.

(5) Providing and developing incentives to attract and retain rural health care professionals, such as tax breaks for those practicing in rural areas.

(6) Stronger emphasis in the role and relationship of health care to the overall economy of rural areas.

(7) Support for the establishment of a State Area Health Education Center program.

(8) Finally, efforts to increase coordination and maximize the resources of State, Federal, and private programs focusing on health care.

Those are a few of the highlights I wanted to cover this morning. You will hear in detail from others.

In closing, I would like to extend our appreciation for your continued support in rural health, certainly for your participation on the House Rural Health Coalition and your active role there and for coming here to Baker, OR, and holding this hearing on rural health.

I welcome any questions.

[Ms. Kilgore's statement may be found in the appendix.]

Chairman WYDEN. Thank you very much, Ms. Kilgore, and I very much appreciate your excellent statement and as Oregon's Member on the Health Subcommittee, I thought it was important to be involved in the rural health effort in the House of Representatives and that is one of the ways we are going to take this record and push for some of the reforms that you mentioned.

Because time is short, I am going to ask you a couple of questions.

One, am I to understand that it is the position of the State that to help stretch resources, to make dollars go farther in local communities, that the State would like to see physician assistants, nurses, social workers, nurse practitioners, these groups play a bigger role in rural health care and, say, be eligible for direct reimbursement from Government programs?

Ms. KILGORE. Absolutely, and Oregon is fortunate and very progressive with nurse practitioners and physician assistants. We have State statutes that require mandatory third party reimbursement to nurse practitioners and certainly physician assistants under their legislation also get reimbursed.

They are critical to our rural health delivery system. As I indicated, many areas of the State would not have any health care services if they did not exist.

Chairman WYDEN. One other question I had. I noted your support for the University of Oregon Health Sciences program with respect to establishing a rural family practice residency program. I think that sounds like a very exciting idea. What do you hope to accomplish with that program and where does it stand at this point?

Ms. KILGORE. I think I would like to defer that response to the individuals who are going to speak from the Health Science Center because I am sure they will talk about it. Dr. Reinschmidt is here and will probably address that. I think they would do a better job than I would.

Chairman WYDEN. With respect to the National Health Service Corps, you are correct in talking about the effort to dismantle it. I think that is a big mistake. I gather that it is the position of the State of Oregon and the Governor that rather than dismantling it, we ought to build on it?

Ms. KILGORE. Absolutely; absolutely.

Chairman WYDEN. I think it is still one of the most promising concepts in that, in effect, it could be much like an ROTC program where people would get assistance through their college and their education at a time when medical expenses are great in return for a commitment to come to underserved areas, work with geriatrics and the like.

Ms. KILGORE. Yes; and in Oregon, Congressman, we did a study of the National Service Corps and its 15 years of experience in Oregon. We have had a 50-percent retention rate of those health professionals that were through the National Health Service Corps that have stayed in Oregon. That is a very high rate for the program and of that 50 percent, 38 percent have stayed in rural areas.

So, it has been very effective in Oregon and we would definitely like to see it continue.

Chairman WYDEN. One last question to follow up on an interest of mine over the years and that is the question of care for older people in rural communities, particularly at a time when the elderly population in rural areas is growing so fast.

It is my understanding that there is really an acute shortage of specialists in geriatrics in rural areas and I was told recently, it came up at either a hearing or a meeting, that the shortage of nurses, for example, in long-term care facilities in rural Oregon is really incredibly acute.

I was told about one instance in rural Oregon where a nurse had to be released because of substance abuse at a nursing home in rural Oregon. The facility then went out and spent a substantial amount of time trying to find another nurse. They could not find a nurse and were faced with the choice of either rehiring the one back who had substance abuse problems or having no nurse at all and they rehired the one back because they felt that, at least, the older people would get some care.

Is the crisis that serious in terms of geriatric specialists in rural Oregon?

Ms. KILGORE. That is certainly what we hear from health hospital administrators, nursing home administrators, home health agencies, and so forth. I think there will be some people who will address that in even more detail and I think you are absolutely correct there. Those kinds of problems are happening all over the State. It is not an isolated incident.

Chairman WYDEN. Well, two points on that and maybe save some time later, one of the things that I hope my nursing legislation will do, it funds demonstration projects to look at ways to get more nurses in the field. One of the things I want my legislation to do and it is going to pass I think in this session of Congress, is to fund some demonstration projects to work with older people in rural areas, to have nurses and demonstration projects to see if we can expand nursing services in rural areas and I hope we will be able to get a demonstration project here in Oregon.

The other initiative that I have that I do not think will pass in the remainder of this session is the one of giving social workers the chance to be reimbursed directly from Medicare in rural areas. I gather you all are in support of that, as well?

Ms. KILGORE. Yes; I recently attended a National Rural Mental Health Association conference and there was lots of discussion with regard to the role of social workers, psychologists, and so forth. It is critical that highly trained mental health specialists are in the rural areas because of the problems that they are facing with mental illness in this country.

We are certainly not going to have the high technical psychiatrists in our rural areas. There are not enough and there never will be. So, it is critical that we support the allied mental health people, the social workers, and also psychologists are very essential or we will not have any mental health services.

Chairman WYDEN. I commend you on a fine presentation. We will look forward to working closely with you in the days ahead and thank you very much for being in Baker today.

Ms. KILGORE. Thank you for inviting me. I have enjoyed working with your staff over the last several years.

Chairman WYDEN. Thanks very much.

Our next panel will be Dr. John Kendall, Dean of School of Medicine, Oregon Health Sciences University; State Senator Gene Timms; and Mr. Mike Nelson, representing the Baker County Medical Society, Baker, OR.

We welcome you.

Unfortunately, I am looking at the clock and the number of witnesses and something tells me that we are going to have to be a little dictatorial on this thing.

If you will keep it to five minutes for your prepared remarks, I do pledge that every word of your written statement will go into the record.

Let us begin with you, Dr. Kendall. It is good to have you here and we thank you for your interest.

TESTIMONY OF JOHN KENDALL, M.D., DEAN OF SCHOOL OF MEDICINE, OREGON HEALTH SCIENCES UNIVERSITY

Dr. KENDALL. Thank you, Congressman Wyden. We appreciate your timely interest in this important subject of rural health.

Dr. Peter Kohler, president of the University was not available because of a previously scheduled activity but he extends his special greetings and wants to let you know that among his very top priorities is outreach in the rural health care area and provision of the education in this sector. He has been active in it in Texas and will remain active here.

We, at the University, share your concerns about the adequacy of health care facilities and providers in the rural and remote areas throughout the United States but particularly interest of us is in Oregon. We recognize the plight of the rural hospital and the provider. With a relatively small number of patients, the hospital and the complex care required of the small hospitals make it very difficult for them to achieve their goal of maintaining open doors.

The maintenance of rural health services is complex. It involves a number of social and economic issues as well as issues regarding direct health care. We have been considering these issues and want to tell you today about three particular areas of our interest but our interests do range from attracting young students into rural health care through advanced continuing medical education for the practitioner in the remote area.

The first of our particular interests involves what we consider to be a unique proposal. It is slightly different from that which Ms. Kilgore referred to regarding residencies in the rural area but I would like to focus on that for a minute.

It is well understood that many of the rural and remote communities face problems in attracting family physicians who are sufficiently broad in scope and in training to manage not only the daily common problems but also the relatively complex problems that because of time and remoteness they must be called upon to handle. The newly trained family physician of today, while very well equipped to handle a broad range of daily problems, is not as well equipped to assume the spectrum of responsibilities in a remote health area.

The family physicians in an urban area may call upon an array of specialists to help solve particular problems and thus is not faced with the difficulties of the family physician in the remote area.

We believe it is feasible to address the particular problems in this sector by the development of more advanced training for the family physician.

We propose two years of family medicine fellowship for those individuals who intend to undertake rural remote practice. Such a fellowship would include advanced training in high risk and opera-

tive obstetrics, in trauma care, in intensive and coronary care, and expanded training in gynecological and general surgery. This is over and above their baseline training that we already give them in the geriatric area.

This would equip them to be able to handle much more than the young family physician can today when he or she enters the smaller hospital. This is important to the hospital. It will help them to maintain the viability of practice in their areas.

The model program concept has been developed by our family medicine department and we are prepared to provide additional information if you wish on costs and details of such a program. We think it is a very exciting idea and we believe it is unique in the United States.

Another important activity I wish to touch on briefly is the Area Health Education Center program. We do not have an AHEC in Oregon. Such a program, as you know, provides opportunity for students and other trainees to engage in first-hand rural health care under the auspices of a medical school and its affiliated professional schools.

For Oregon to be participatory requires expansion of the program at the national level beyond where it now stands and we have been appreciative of your interest in following the AHEC programs and it would require not only authorization but expansion of the funding for Oregon to be participatory. We are anxious to do that and Dr. Kohler has placed that as number one among his outreach programs.

A third area of interest concerns an evaluation of the present reasons for the attractiveness of some communities for rural health care providers. This has been studied in the past, we know, but we would like to look at it again now as to why some communities are particularly able to attract physicians and others not so that we could provide assistance to them in making their communities more attractive for obtaining health care providers at the physician level as well as others.

Thank you for the opportunity to testify today, Congressman Wyden and we are very grateful that you have taken the time to do it.

[Dr. Kendall's statement may be found in the appendix.]

Chairman WYDEN. Doctor, thank you and I will have a couple of questions in a moment.

Senator, we welcome you and we know of your long-standing interest in these matters and will make your presentation a part of the record and look forward to your testimony.

TESTIMONY OF EUGENE TIMMS, OREGON STATE SENATOR

Senator TIMMS. Thank you, Congressman Wyden. I appreciate you holding this hearing in real rural Oregon where you can see firsthand the problems that we have in regards to rural health. I have been very active in regards to this in the 1987 legislature and have had the opportunity to attend numerous meetings on the subject.

Rural health care, as you know, is a very important issue to Oregon and throughout this Nation. Although the problem is still

acute in Oregon, this State is leading the Nation in trying to solve rural health problems.

Recently I attended a 4-day meeting at Timberline Lodge which I am sure you are familiar with where we had people throughout the United States discussing the rural health problems and I felt good that we had done as many things in Oregon as we have and I will allude to some of those today.

But first I think we have to mention DRG's and the problems that we have had with the Federal Government in how they fund those and penalize rural hospitals and rural doctors and that certainly hurt the process.

In the Oregon legislature we passed Senate Bill No. 428 which has helped, and will continue to help, rural hospitals' health care in Oregon. First it allowed Medicaid financing to 100 percent at the eight "At-Risk" hospitals in the State. For hospitals such as Baker, I would guesstimate that would be between $70,000 and $90,000. In my home town hospital in Burns which is much smaller, it is between $40,000 and $50,000 which I think has helped save some rural hospitals in the State in the "At-Risk" category.

Also we prioritized technical assistance in Senate Bill No. 428 which Marsha Kilgore alluded to and I will leave that out of my testimony.

We also had a meeting at Baker, we had the eight "At-Risk" hospitals and I think this points out something that should be important to the Federal Government as well as the State government that you find problems when you meet with the people at the lower level, the bottom, the grassroots level. I think these people when they go to association meetings many times are caught up in the volume of other people and most hospital administrators from St. Vincent or big hospitals are better qualified in some cases. In some cases I wonder if they are or not because I think we have some excellent hospital administrators but still I think you get to the basic problems better and that meeting was one of the key meetings we held.

For instance, we came up with skilled nursing beds and how to use those which have helped rural hospitals. We came up with a waiver of the certification of need which is helping rural hospitals. We have made accomplishments of the tying of rural health to economic development and that is another factor that I think in Oregon we have been successful. Ellingson Lumber, John Day Lumber many of our industries would not be in the rural communities unless we had health care and that has given them the opportunity to exist.

Hospitals are one of the biggest employers in our small communities. Six-tenths of one job in the community is created by one hospital job.

Emergency medical service, along with the 911 number which we are ahead of many States in the United States, are important in Oregon to save life and property which lowers the cost to small businessmen in regards to their insurance rates because we have these types of services.

In rural areas the population of retired persons is growing and these people are much better off financially. We are seeing more people retiring that have better financial benefits than they have

had in the past. In 1980, one in every nine persons was over 65. In the year 2030, one in every five will be over 65. 18 to 20 percent of the income in Baker County comes from retirement income. These people are dependent on health services.

At this time I would like to also mention in Senate Bill No. 428, the definition of rural and the type of hospitals because it has not created any problems for us. It might be something you could look at nationally.

A type A hospital which is the definition for the eight "At-Risk" are hospitals that are small and remote, have fewer than 50 beds and are greater than 30 miles away from another acute care facility.

A type B hospital is one that is small and remote, has fewer than 50 beds and is less than 30 miles away from acute care, in-patient care facility.

Type C are hospitals that have more than 50 beds but are not a referral center.

As I mentioned, it set up five technical assistance areas, Marsha mentioned the most important ones so I will skip through that.

The final part of this legislation that made it so important is the fact that we put into the State economic development policy in the State of Oregon the "availability of health care services in underserved areas," which will allow us to use lottery funds and to look at other means of financing for equipment for hospitals, for ambulances and other means EMT's and those types of services.

Too many times we forget the health clinic, the EMT's are the other part of rural health care and we need them. Many of those are the ones that are really hurting. I have some health clinics right now that are closed in Christmas Valley, for instance, in Lake County and that is the bottom, so to speak, of the ladder and we cannot forget the importance of those.

Politically in the country, economic development—Health care—means "jobs."

I know we made it work in Oregon. If we had put it in to the human resource committee, it would have never seen the light of day because everybody is at the trough and you cannot get it done. But I cannot overemphasize that we need to relate it to economic development in rural Oregon.

In conclusion, I believe we have taken strides in the State of Oregon to improve health care. It has been a bipartisan effort. We have worked toward it, my representatives, Senator Thorne, whom I am sure you know in the northeastern part of the State, Senator Kitzhaber who is a doctor and is president of the Senate in health care legislation in this State.

Marsha Kilgore, who is president of the National Health Care Association, I think is a credit to this State and the reason she is there is because she is better versed and she has done things in Oregon.

The Oregon Health Sciences University, we have met with. They are in attendance today, have been in attendance in many of our meetings and are working to increase the programs for doctors, for continued education and I think that is important.

It is a privilege for me to be here and I certainly appreciate you coming to eastern Oregon to bring us this forum on health care be-

cause I think we have some things in Oregon we can be proud of and we still have to solve some of those problems and many of them are Federal. I certainly do not understand all the Federal problems but I know they are many, but thank you very much.

[State Senator Timm's statement may be found in the appendix.]

Chairman WYDEN. Senator, thank you very much. That is a very helpful presentation, particularly to go through that Senate bill. We will have some questions in a moment.

Mr. Nelson, we welcome you and know also of your long-standing interest in this and look forward to your testimony.

TESTIMONY OF MICHAEL NELSON, BAKER COUNTY MEDICAL SOCIETY

Mr. NELSON. Thank you. I am Michael Nelson, owner of Nelson Real Estate here in Baker, OR. We appreciate you being here, Chairman Wyden.

The people of Baker have worked hard to successfully initiate a local economic recovery. The Baker Industrial Development Commission, Baker Industrial Resource Commission, the Baker County Chamber of Commerce, the Baker City Council, and the Baker County Court have all done an admirable job in effecting that recovery.

However, a major catastrophe is on the horizon that will nullify all of these efforts. The catastrophe is the possibility of losing our hospital and physicians. Without them, the cornerstone or economic stability, our communities will become an economic wasteland.

In making economic development proposals to companies which are considering locating in Baker, we have found that one of the first questions they ask is, "Tell us about your hospitals." They want to know how many physicians we have. They want to know how many beds are in our hospitals. A community without decent health care simply cannot attract new business.

If something is not done to remedy the current situation, several rural hospitals in Oregon will be forced to close their doors and those communities will be closing the doors to new business.

I have presented you with comprehensive documentation assessing the sources of rural health care crisis. The Baker County Medical Association feels that the number one problem is the difficulty in recruiting and retaining physicians in rural areas.

Add to that an unfair, and I stress unfair, Medicare reimbursement program for rural versus urban hospitals and physicians, inadequate Medicaid reimbursements to physicians and the generally poor economic health of rural Oregon and we indeed have a funding crisis on our hands. The crisis is exacerbated by the higher percentage of Medicare users in rural areas and the subsequent drain on already insufficient Medicare funds.

Doctors practice in Baker because they like it here. Many of us live here because we like it here. They do not want to be forced to leave, Congressman, and we do not intend to let our economic recovery backslide.

The documentation I have provided you with, outlines some proposals we can act upon to ensure our physical and economic health.

One of the main components to this entire process is our physicians. I would like you to explore instituting mandatory tax incentives for rural physicians. I think that is a reasonable solution to encouraging physicians to come to rural parts of Oregon.

Providing for a continuing education for rural physicians through AHEC which we have already talked about which most people here are aware is federally funded. We would certainly like to locate that eastern Oregon State College.

Three, creating a Medicare reimbursement program which favors rural hospitals rather than discriminating against them.

Four, increase Oregon's Medicaid reimbursement for physicians.

Five, entertain the possibility of creating an Eastern Oregon Office of Rural Health.

There are many more common sense solutions enumerated in this document. Chairman Wyden, all of our work and all of our solutions go in vain without dedicated, caring people like you. We need your help. Your legislative history clearly exemplifies you have a sincere desire to help rural areas and the elderly.

We ask you to lead us toward implementing some of these solutions. Our schools, our Government, and our communities are depending on it.

Thank you very much for allowing me this opportunity.

[Mr. Nelson's statement may be found in the appendix.]

Chairman WYDEN. Well, Mike, thank you for a helpful presentation and Senator Timms said it very well, I think, when he said this is a bipartisan effort and I appreciate you being here today.

I have a couple of questions.

Dr. Kendall, with respect to your family physician program, I gather that you are now putting this in place and it is just beginning. Can you tell us what you expect to achieve with this in terms of how many physicians would be trained and over what period of time you would expect this training and education to become available?

Dr. KENDALL. Congressman, we have a family medicine residency program which has been funded by the State for about 20 years now. It is a 3-year program with eight entrants and eight graduates every year. That provides a baseline and the basal training which I have mentioned previously.

For the rural areas advanced training for these kinds of individuals would narrow down the number and we would propose initially to have two fellows who would participate not only activities at the Health Sciences University but out in the communities through rural preceptorship, two a year.

Chairman WYDEN. That is new.

Dr. KENDALL. Yes; that is new. We do not have the funding for that and that is key. We have the funding for the eight per year already. The two others would be new.

Chairman WYDEN. Are there Federal sources that you are looking to for help in trying to expand the family physician program in rural areas?

Dr. KENDALL. Because it is a unique idea, we do not think it has been presented before, we would look to all sources. We would look to the State. We will be looking to them this fall. We will be looking to Federal sources if available but none are available, particu-

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larly at the present time. I think new legislation would be in order for this kind of program.

Chairman WYDEN. Well, the one thought that comes to mind is that there are model project funds available for approaches that are experimental and unique and that would be probably, the first thing that I would want to follow up on is to see if perhaps the expansion of the family physician program that you all envisage might be something that could qualify for a demonstration project because then you are talking about existing funds.

Dr. KENDALL. That would be great.

Chairman WYDEN. And you would like to have that up and running in the next year or two.

Dr. KENDALL. Indeed, because we believe it is the early solution, a rural residency program would be a longer term solution. That would take several years to achieve its full capacity.

Chairman WYDEN. So a fellowship program you hope to achieve fairly soon in terms of rural physicians. You would start with just a handful of individuals and hope to go from there and over the longer term, you would hope to have a family physician program.

Dr. KENDALL. In the rural sector; yes.

Chairman WYDEN. How would you see that being financed because that is new as well I gather.

Dr. KENDALL. Indeed. We would look to State sources to help us in that as well as our own internal sources at the University.

Chairman WYDEN. And the University is prepared to commit additional resources to these projects as well?

Dr. KENDALL. Yes.

Chairman WYDEN. Senator Timms, I very much appreciate your walking me through that Senate Bill No. 428 and find that very helpful.

My question is a philosophical one. Because there is a lack of health care facilities in rural areas, would you see hospitals playing a bigger role down the road as the center of health services in a community, perhaps offering preventive services, perhaps offering home health services? Is that what you envisage at the State, the rural hospital playing a bigger and bigger role as, in effect, the only ongoing resource in a community?

Senator TIMMS. Congressman, I think it was pointed out in that Timberline meeting, Montana had—under some Federal laws which I absolutely get confused when you start looking at all the laws of what is allowed and what is not allowed—but they were setting up certain types of clinics under different situations that we look at today.

I think hospitals are like any other business, that you have to manage them properly and I think that you have to be innovative and look at ways of providing health care in communities and you have to have an economic unit that will make it work. Most of our hospitals in rural areas are county or under governmental units. Therefore, in many cases, sometimes they have the tendency to not be run as efficiently as they should because in many cases, they are using tax-payer dollars. Therefore, there are some questions in regards to management.

I think if we look at the total process of health care we will have to be innovative, we will have to incorporate nursing homes in

with hospitals as they have in Baker. They have an excellent nursing home here. It is a new facility and that is the case in many of my hospitals they do have nursing homes with them.

So that is an example of an incorporation into the hospital program and I think there are many ways that there is flexibility but many hospitals do not know about those that are allowed under Federal laws, the flexibility with nurse practitioners, those types of things.

I think that we need to be better versed in the hospital field especially in rural areas of what actually can be done as far as flexibility and be more flexible.

Chairman WYDEN. Well, I think that is very, very helpful. As you look to the future in rural health care, the question is how can you build on some of the stable resources and my sense as I look in Oregon and listen to witnesses in Congress is that in many communities, the hospital is the anchor. It is going to be there. It is a stable ongoing health program and to the extent that we can build other services on to it, that is a way to make programs cost effective.

For example, say you want to run a preventive health program for older people and the evidence is that preventive care for elderly people can save an awful lot of Medicare Part A, the hospital costs.

Rather than go out and set up a separate program of preventive health care, what we may want to do is graft it on to the hospital program where a small portion of the hospital, in effect, is devoted to shots and various things like that.

I am very interested in working with you on this and I share your view. The question is management effectiveness and cost effectiveness so probably what works in one community will not necessarily work in another and as we look to the role of the hospitals in the future, my sense is that there are talents and opportunities there to fold in some of these other programs, not just nursing homes and I think that is a very good one but things like preventive health care. Home health care is an example and your point is well made.

One last question for you. With respect to Senate Bill No. 428, did that have anything to do with recruitment and retention issues as it relates to health care providers in rural areas?

Senator TIMMS. It certainly did. That was the number one priority of the five technical categories and here when we had the meeting the "At-Risk" hospitals came up with that. Also the rural health meeting which I attended in Eugene of all the rural hospitals in the State of Oregon, came up with that as the number one priority—retention of professional people.

Jeff Butler, who is here today is the person who was hired to take care of that under Marsha Kilgore and doing an excellent job.

Chairman WYDEN. So that was your first priority under 428?

Senator TIMMS. That was the first priority of the five technical assistance areas, that was the number one priority.

Chairman WYDEN. Thank you very much and certainly we look forward to working with you in the days ahead.

Mike, thank you for a very helpful presentation as well. I have one question. What is the status of home health care in Baker and

has there been additional problems over the last few years getting home health care services to older people in Baker?

Mr. NELSON. Well, of course, one of the problems with home health care in rural Oregon is the recruitment, the whole recruitment factor of getting qualified nurses and providers to come to rural Oregon. If you open the Sunday Oregonian, and look in the classified section, the number one ad is for nurses and we cannot compete with urban areas. We cannot offer the benefits and the perks that providers get in the urban areas and that is why we need this assistance.

Since we have such a large arena of seniors, home health care is a very vital part of our everyday life.

Chairman WYDEN. As of today, there is a distinct lack thereof.

Mr. NELSON. Well, we do in rural areas, I use this word in so many of our areas, we get by but it certainly could be improved.

Chairman WYDEN. One of the areas that I have been very unhappy about and there has been bipartisan concern in the Congress is that the administration has really ratcheted down on home health care administratively and a judge in United States District Court in Washington essentially threw out their proposals to ratchet on home health care.

I really hope that this is one area we are going to expand on in the years ahead. We talked last night with the senior citizens about the catastrophic care bill and that bill is a mixed bag at best with a lot of problems, but one part of it, will really help in rural Oregon and one that I worked for very hard, called the respite benefits. What this means is that you have an older person being cared for at home, you get some help to the care giver before the care giver gets exhausted and you have two people needing nursing home care.

So, it is a small benefit. It is only an 80-hour benefit but it is one that I think really will help some in rural areas. It is one that we can get off the ground quickly because it was part of the catastrophic care legislation and I really hope that will be a start toward more home health care in rural areas.

Let me ask one other question of both Senator Timms and you, Mike. The question of how to get more personnel and individuals trained in rural areas to deliver care is one that has many ramifications from Senate Bill No. 428, the family practice program at the University of Oregon Health Sciences Center.

We are hearing more discussion now that in rural areas, the providers that are there such as the hospitals and nurses might consider training other people in the community, say seniors or family members or others, bring them into a program and offer them some training so that they can then go back out in the community and watch for others and particularly help on things that are not acute care.

Do you see that as a viable possibility and something that would be of use in this area? Senator?

Senator TIMMS. Well, Congressman, I certainly think it would be of use if you could do it. You know, as you understand better than I, the flexibility sometimes and the turf battles that we have over doctors, nurses' training, this and that, in that process.

I would like to visualize that we would be able to individually train. It is a training process in the hospital anyway. There is continued education that 's going on every day. I would like to see that happen and I think that is one of our biggest problems and one that we have to face is that we are so remote from training in the State of Oregon.

Eastern Oregon College is the only higher education institution east of the mountains other than OTI in Klamath Falls and I am not sure what they offer in regards to nurse training.

But sure, we need to find more flexibility in how we train people because our biggest problem is finding them and training them at the local level. They have a local environment that they are used to and they will probably stay. People come in from the outside and leave.

Chairman WYDEN. Mike, anything you wanted to add on that?

Mr. NELSON. Yes, Congressman, I think we need to concentrate on how do we move people from A to B and we do that through incentives and working with the economic development department, working with the Senator here. We bring a new company to town and we have offers for them; we freeze their property tax, we give them free land, we give them interest-free loans. We discount their utilities and yet the most important basis is our hospitals, physicians, and our nurses. Why are we not doing that for them? Why are we not giving a tax incentive to move to eastern Oregon? I think that would be a simple solution to encourage some of these people or give them a tax incentive to get involved in training or a multitude of other incentives.

Training is vital and we forgot one thing. I do not think anybody has mentioned here, training this time of the year is not too bad to drive over to Eugene. We have about five months out of the year here that sometimes it is a two-day trip to go to the west side for training. We need our own training center in eastern Oregon.

Chairman WYDEN. Well, you all have made very thoughtful comments and, of course, what we are trying to do is really look down the road, this question of training as Senator Timms has said involves some additional flexibility in doing it. It is my sense as people talk about family and friends, it is not very plausible to suggest that your neighbor is going to come get training at a hospital and be able to take out somebody's appendix. Nobody is talking about that.

If, for example, a friend or a neighbor can get some additional training in helping with assistance around the house, doing chores, being able to spot major medical problems and alert professionals, that may be a way to make the resources stretch.

Frankly there are a lot of new technologies that I think are getting much closer to being available. We were told on the health committee about the notion of what would be called "the hospital on the wrist," where, in effect, through a special watch on your wrist, you could find out about certain kinds of medical problems you were experiencing and, in effect, it could be hooked up to a local hospital so that communication could be gotten in that way.

That clearly is also a long way down the road but the name of the game is going to be, as all three of you have suggested, being flexible and looking at innovative kinds of approaches.

I am going to do my best to make sure that the Federal Government is a better partner to all of you so that you are going to have the tools and the resources to initiate some of these good efforts. I commend you for these good efforts and I also commend you for what you are doing. I look forward to working with you closely and this has been a fine panel.

On our next panel, Walter Busch, administrator of St. Elizabeth Hospital, Baker, OR; Don Everson, fire chief, Baker, OR; Mike Herron, president of the board, Southeast Oregon, Rural Health Network.

Gentlemen, we thank you for coming and we thank you for your patience. We will make your prepared statements a part of the record and if I can ask you to stay to five minutes, that would be very helpful.

Mr. Busch, let us move that microphone closer so everybody can hear your valuable testimony and we will let you start off.

TESTIMONY OF WALTER S. BUSCH, ADMINISTRATOR, ST. ELIZABETH HOSPITAL AND HEALTH CARE CENTER

Mr. BUSCH. I too would like to thank you, Representative Wyden, for taking the time to come to Baker and listen to the problems we have directly.

A lot of my comments have already been mentioned by other speakers but to briefly summarize, in our hospital we are facing a financial disaster, primarily because of the Medicare reimbursement methodology.

There are cases that we care for which we may lose anywhere from $3,000 to $20,000 or $30,000 on. Without sufficient volume in a small hospital to compensate for that through averaging on cases where there is some profit, the bottom line for the hospital is quickly eroded.

The Senate Bill No. 428 that was mentioned by Senator Timms affects our hospital and one incident that I mentioned in my testimony the difference between the Medicaid DRG payment we would have received for a critical case and the actual cost base that we did receive was about $20,000 about a year ago.

Medicare, however, constitutes about 52 percent of our revenue base and, in fact, when you average out the total effect of Medicare on the hospital, we are losing about $0.13 on every dollar of cost to treat a Medicare in-patient right now because of those significant outlying cases, we averaged them in.

With that representing 52 percent of the base of revenue, no matter how innovative a hospital is, it is really almost impossible to overcome that.

We have tried many innovative approaches. We are currently involved in a consolidation, in effect, with St. Anthony's Hospital in Pendleton to try to cut overhead between both facilities and we think by sharing, for example, the chief financial officer and other positions and sharing computer services, we can probably affect a savings of $100,000 or more, working together.

But that is not enough to offset the losses that we experience through the Medicare program.

I was interested in your comments about training people in the community to help care for family members at home. I think there is a lot of merit in that and St. Elizabeth Hospital and Nursing Home conduct certified nurse aide training programs which are open to the public and we have had many people in the community attend those for the very reason you mentioned.

Limited human resources and financial resources on our part limit the number of times we can do that but they are effective and they do help people at home as long as possible.

I think you will find that rural hospitals are very innovative and are anxious for new ideas to try to be more effective. Our hospital has physician specialists coming from communities in Pendleton, La Grande, and Ontario, OR, on various days of the week to hold outpatient clinics both to be a convenience for the residents of Baker and also to help better utilize hospital resources.

We have an active home health program, the second oldest in Oregon. We have a home oxygen program. We have an intermediate care facility. We have swing beds. We are doing all we can think of to, at least, break even but until the Medicare program finds a way to pay a fair share of the costs, we simply cannot win the game, we do not think.

[Mr. Busch's statement may be found in the appendix.]

Chairman WYDEN. Thank you and we will have some questions in a moment.

Mr. Everson is next.

TESTIMONY OF DON EVERSON, FIRE CHIEF, BAKER, OR

Mr. EVERSON. My name is Don Everson, I am the Baker fire chief.

The Baker Fire Department provides basic life support ambulance service to the city of Baker and also to a large part of Baker County, part of Grant County in the Granite and Austin Junction area, and part of Union County in the North Powder, Medical Springs, and Ponderosa area.

The ambulance service, as an integral part of the Baker Fire Department, is funded out of the general fund of the city of Baker with no support from Baker, Union, or Grant Counties.

The user fees for ambulance service to nonresidents of the city of Baker are increased to help defray some of the expenses of providing ambulance service to some of these areas. Base rate for residents of the city of Baker, for instance, is $100 plus $2.00 per patient mile. Base rate for nonresidents of the city of Baker is $300 plus $3.00 per patient mile.

In 1987, 218 calls out of a total of 595 were for service outside of the city. Time in service was 392 hours for outside city calls out of a total of 601 hours.

Miles traveled in service was over 12,000 for outside calls out of a total of 15,000.

The Baker Fire Department has 12 full-time paid firefighter EMT's who are trained to the EMT-1 level.

While any increase in the level of training for fire department personnel would be beneficial to all patients, the biggest impact

would be on the long runs out of the city where the only care possible, for sometimes several hours, is the EMT on the ambulance.

The city of Baker is faced with three major problems:

(1) The expense of providing ambulance service into the rural areas;

(2) The expense of maintaining and increasing the level of training; and

(3) The difficulty in finding available classes and instructors for Level II training and above.

Thank you.

[Mr. Everson's statement may be found in the appendix.]

Chairman WYDEN. That concludes your statement?

Mr. EVERSON. Yes.

Chairman WYDEN. Very short but well said. Thank you.

Mr. Herron is next.

TESTIMONY OF MIKE HERRON, PRESIDENT OF THE BOARD OF DIRECTORS, SOUTHEAST OREGON RURAL HEALTH NETWORK, CHILOQUIN, OR

Mr. HERRON. Thank you, Congressman, for the opportunity of being here and I would also like to thank Erin for all the assistance that she provided in the process of getting things together for this.

A lot of what has been said would be reiterated by the Southeast Oregon Rural Health Network, SORHN, of which I am the president of the board of directors.

The needs of the rural segment of our population are clear. What is not clear at this point in time is our Nation's commitment to meeting all those needs.

I would like to focus my remarks on two areas of increasing concern to SORHN. One, what must be done to ensure the availability of health care services in rural communities and two, I want to talk about the AIDS public health epidemic and the impending impact of this disease in rural areas.

First, I will give you a fact about health care services. At the SORHN board of directors meeting on July 27, 1988, a motion was unanimously approved to temporarily close the North Lake County Health Center effective August 16, 1988, until the following conditions are met:

(1) A full-time health care provider, either a physician's assistant or a nurse practitioner, can be recruited and certified in the State of Oregon.

(2) A physician preceptor can be located in the La Pine/Bend area to ensure quality of care and patient continuity concerns are better addressed.

(3) Until supplementary funding can be located to cover the expected operating losses and the clinic can build its client flow and operate on a self-sufficient basis.

A couple of people have alluded to this and there was an article in the Oregonian about the closure of this center.

The decision to close the North Lake County Health Center did not come easy for the SORHN board of directors. We realized that

the residents of North Lake County are once again without any primary health care services within 100 miles.

However, the board had to balance the issues of financial responsibility, we cannot operate at a loss, quality of care, the difficulties involved in adequately providing supervision from 100 miles away as well as continuity of care for the patients, and our commitment to providing health care for the residents of the communities that participate in our consortium.

The problem is, and you have heard it from several people before, we are currently unable to locate a mid-level health care provider who is willing to work full time and live in the community involved. Despite extensive advertising, networking with other health care organizations, and other recruitment efforts, SORHN has been unable to locate a qualified applicant.

A potential solution and it has been mentioned again is to re-establish or shore up the National Health Service Corps or some similar entity and have a major focus on training mid-level providers in addition to physicians. Offer scholarships which can be worked off through service provision in class one health manpower shortage areas.

Another problem, even if we were to locate a qualified applicant and negotiate an acceptable compensation package, the certification process and preceptorship requirements make it virtually impossible to adequately supervise providers in remote locations, accomplish the certification and other paperwork processes in less than six months, and ensure quality-of-care issues are satisfactorily addressed.

I think one of the solutions to this and this has been a favorite topic of mine for a number of years, is when legislation is drafted nationally, statewide, or locally, make sure that practitioners are consulted as in these hearings and that their input is taken into account.

Then once the legislation is passed and the procedures and regulations that are going to put that into place are drafted, get practitioners, the actual service deliverers involved in the writing of these regulations because as it is now all too often the regulations that get written, systematically preclude you from carrying out the intent of the laws that are enacted.

Another problem is that rural health clinics, like other start-up enterprises, will experience operating losses until the clientele is established and services are in full operation. It is particularly acute for non-profit organizations with no capital resources to defray losses and yet the services have to be available on a full-time basis if you are ever going to build them up and assure community utilization.

A potential solution to this is to provide some form of subsidy or incentives during start-up periods to defray anticipated losses until the clinics are operating profitably. I am not advocating giving the fish to people, I am advocating teaching them to fish and helping them over the initial shock of that.

We do not like characterizing consortium and our clinics as being federally funded because of the "welfare mentality" that that raises in the community. I think that it should take some kind of interest-free loan to help them get started or else make it some-

thing like a scholarship program where if they maintain services for a period of time that it is forgiven.

Another problem is that individual clinics cannot afford necessary overhead costs to keep fee for services at competitive levels and maintain professional management capability. Clinics must be able to operate effectively and efficiently, be financially responsible, be effectively administered, use cost-saving techniques and procedures and so forth.

I would suggest that all legislation enacted and funding which is given should promote and encourage the concept of consortium building to spread the management costs, keep the maximum amount of money in the actual service delivery and hold the consortiums accountable and responsible without throttling them so they cannot operate. Determine which models work and disseminate the findings together with technical assistance so that other communities can develop the same thing without having to reinvent the wheel.

I would like to switch to something that has not been addressed very much recently or so far in the testimony that is presented but I am very concerned about it personally for a couple of reasons. One, I think AIDS is going to become the worst public health epidemic that we have ever seen unless something is done about it. Second, we have the tools to prevent the spread of the disease and we need to put them into effect.

By the way, before I go into this, AIDS has not yet impacted rural areas as substantially as it has in urban areas for a variety of reasons but one of the facts that I am aware of is that public health experts are predicting that by 1991 every man, woman, and child in the United States will either personally know someone who has either died of the disease or is currently infected with it.

Although there is as yet no known cure for AIDS, the spread of the disease can be prevented. Further, the quality of care and services for those who have contracted the disease can be substantially improved.

Persons who will be infected with it in the future are not only the high-risk people whom we have all heard so much about. It is not just going to be from the gay population or intravenous drug users.

Many of us have heard the story of Ryan White, the 16-year-old hemophiliac who has been fighting a struggle with AIDS for several years. That is one story that got a lot of notoriety; not all of them do.

On Sunday, July 24, 1988, a 12-year-old boy named Nathan Henderson died of AIDS. His father, Dan, is a good friend of mine. Nathan had been diagnosed with leukemia at age five in 1981. He underwent two years of chemotherapy and the leukemia was pronounced in complete remission.

Unfortunately, a part of his therapy included transfusions and in 1986 Nathan was diagnosed with AIDS. He got it from contaminated blood during the transfusions. The tragedy did not end with Nathan contracting the disease. His uncle, terrified of the virus forbid Nathan any contact with his family. Nathan never saw his two favorite cousins again.

Nathan and his half-brother and half-sister all attended the same private school. The owner, afraid of parents who would pull their children out when they learned Nathan had AIDS, even though he could not attend school because of his physical condition, threatened to throw out his half-brother and half-sister. A concerted education effort by Nathan's doctors finally prevented that, but it was not easy.

Nathan's dying process was unnecessarily lonely, isolated from many members of what should have been his support system. Although their presence could not have cured him, they could have made his final days, months, and years much happier and more positive. Ironically, because of the very nature of AIDS Nathan was much more at risk of acquiring a fatal infection from others than they were at risk of acquiring AIDS from him.

I personally notified his father, Dan, of the qualified successes of the drug AZT in the treatment of AIDS in the spring of 1986. Dan discussed this with Nathan's doctors that very same day and an application to use AZT in Nathan's treatment was submitted. For whatever reasons, Nathan was not allowed to receive the medication until October 1987. Between the onset of the treatment with AZT and his death, Nathan was actually able to experience some quality time when he appeared and felt like a "normal" child. Why was this delay in treatment necessary?

A similar story comes from a lady in Massachusetts named Marilyn, who in treatment for cancer received a number of blood transfusions. Despite repeated requests to have AIDS testing, and to have the blood certified, it was not done. The legislation did not come into effect until two years after she had received the transfusions or at least the policies to have it done. The $100,000 it would have cost to screen the blood supply will cost millions to provide health care for those it exposed the disease to. What do we do?

What does this mean for rural areas? I will not go into all of this but I asked a colleague. Since I could not gather much data from Oregon, I asked a colleague who runs a program in North Dakota. She said:

> What does this mean for rural health care? Traditionally, rural communities do not have the necessary facilities, equipment, or personnel to provide adequate health care. When we apply this to AIDS the problems are even worse because of the nature of the disease.
>
> The testing issue has recently surfaced in North Dakota because of our ruralness. We are currently working with a client who needs to be tested and both the client and family members are afraid to go on for the test because of the confidentiality issue. Everyone knows the test is supposed to be confidential. However, everyone in a small town always knows everything about everyone else who lives there!
>
> Because of the lack of medical facilities, equipment, and personnel in rural areas, AIDS patients are forced to travel long distances to seek treatment and as their condition worsens and they become less ambulatory they need home health care services which are more accessible.
>
> The Native American population has had an incredibly dramatic increase in cases on a national basis. During one 4-month period the number of active AIDS cases among Native Americans doubled from 26 to 53. It is difficult to track the exact number because they are in Center for Disease Control's "other" category and are not listed separately.

In North Dakota, Native Americans have the highest rate of sexually transmitted diseases. They have the highest rate of unemployment and poverty. They also have the poorest overall health

care and the highest addiction rates to drugs and alcohol. The Health Department considers them extremely high risk and wants to take preventive action quick.

One of the problems is preventing the spread of AIDS. One of the solutions is making the education of the public and organizations working with the public one of our highest national priorities. We need to educate people about how AIDS in contracted and passed on, prevention measures to prevent the spread of the disease, acknowledgment that all segments of our society are at potential risk of AIDS.

Another problem is improving the quality of life for those who have contracted AIDS.

In addition to making health care services available, we must again educate the public about the myths surrounding AIDS, who is at risk of contracting the disease, and how the disease is actually transmitted. We must overcome the mass hysteria surrounding the AIDS issue and we must educate everyone if those afflicted with AIDS are to be able to die with dignity, receiving compassionate care and support from their families, friends, health care providers, and other support systems.

The other problem is, of course, finding a cure for AIDS. We must allocate all possible resources, financial and otherwise to this end. We have to work cooperatively with scientists and researchers throughout the world without regard to cultural or national barriers.

We must put all possible solutions for curing AIDS, alleviating the discomfort for those afflicted with AIDS, and preventing further spread of AIDS, into practice without undue delays.

A summary regarding the rural health care issues. If one of the objectives of this country is to ensure equal access to quality health care services for all of our citizens then what we must do is clear. We must remove the barriers that exist for the provision of services in rural areas. We must direct our educational institutions to train the necessary health care providers. We must determine efficient and cost effective service delivery models that work for diverse rural populations. We must disseminate these findings where needed and we must provide the resources to make the transition to a self-sustaining capacity.

We constantly hear that it is rural and middle America that make this country great. Let us prove that we mean what we say.

A conclusion regarding AIDS, to sit idly by while countless numbers of our citizens die, to allow misinformation to make the dying and grieving process more painful for those involved, to allow a disease to spread when we have the means to prevent it, is a flagrant travesty of the values we so adamantly espouse to others.

While we struggle to find a cure for AIDS we must educate everyone about the disease and how it is transmitted. We must remove the artificial stereotypes that have been created about those who have AIDS and treat them with the dignity and respect they deserve as fellow human beings.

We must use all the resources we have to stop the spread of the disease. We have the communications tools and the knowledge necessary to accomplish this. To do less is to deny the value of the individual, the cornerstone upon which this country was founded.

Thank you.

[Mr. Herron's statement may be found in the appendix.]

Chairman WYDEN. Thank you very much and I want to ask some questions about this AIDS matter specifically.

My understanding is that the numbers are lower in rural areas with respect to AIDS but I gather from your testimony that you feel that there is an inadequate range of services, education, voluntary testing, and counseling now in rural Oregon which, of course, would be the best ways to prevent the spread of AIDS in rural Oregon in the future. Is that correct?

Mr. HERRON. That is correct, yes.

Chairman WYDEN. I am also told that while the number of AIDS cases today in Oregon, in rural Oregon is relatively low, the number of instances of other sexually transmitted diseases is on the rise in rural Oregon. Is that correct?

Mr. HERRON. As far as I know, that is correct, yes.

Chairman WYDEN. I would like to bring Ms. Kilgore back for a moment because I want to get into this in some detail.

Thank you for staying and for your help.

Is that your understanding as well that the number of AIDS cases is relatively low in rural Oregon but the number of instances of other sexually transmitted diseases in rural Oregon is on the rise?

Ms. KILGORE. That is correct, as well as the increase in teenage pregnancy in the rural areas and there are a lot of youth problems in our rural areas. Those are two of the health care issues.

Chairman WYDEN. Why do you think that there is an increase in sexually transmitted disease in rural Oregon?

Ms. KILGORE. Certainly, I think you can look at lack of adequate education and prevention promotion. Certainly our health departments have been doing the best they can with the resources they have to help in this arena but I do not think they are getting out as much as they would like to just for simple lack of resources. Those are part of the problems.

Increasing issues in rural areas with lower economies, family problems, certainly the farm crisis which may be more focused in the Midwest at the present time, has really increased the number of depression and other related problems for the youth today.

Chairman WYDEN. What are the sexually transmitted diseases that are on the upswing in rural Oregon, Ms. Kilgore?

Ms. KILGORE. To my knowledge they are herpes, I would imagine the traditional gonorrhea. We have seen a lot of syphilis with regard to the migrant seasonal farm workers and that impact is really unknown, what is happening in that arena in our rural areas. Certainly there is much concern with our own health division about AIDS and the migrant seasonal farm workers.

Dr. Kendall or Dr. Reinschmidt might have something else to say to that.

Chairman WYDEN. I am going to leave the record open on this point, Ms. Kilgore, for any information you could give us on the incidents of increased sexually transmitted disease in rural Oregon. I think it is very important. For additional information from Dr. Kendall or other witnesses, we will leave the record open.

It was my feeling that the question of sexually transmitted disease in rural Oregon is really fighting a two-part strategy. One is to make sure that there is adequate education, voluntary testing, and counseling programs put in place to prevent the spread of AIDS in the rural part of the State and I think you two have made that point very well.

Then the question is taking additional steps to stop sexually transmitted disease in other areas and you have mentioned herpes, syphilis, and gonorrhea as three other areas where you believe there is now an added increase.

So we will hold the record open and what I would like is as much detailed information on the increased incidence of sexually transmitted disease in rural Oregon, who the population groups are because I would like to use that as new information to build a case to try to get more assistance in the rural areas to fight these sexually transmitted diseases. I commend you for your leadership in that area because I think it is very important.

Let me ask you one other question before we leave this. I am becoming more and more concerned about the problem of medical wastes and my subcommittee held a hearing on this matter in Washington DC, about a week or 10 days ago.

We do not have much information on it. One of the things, in my view, is that the Federal Government has really bungled the job. The Environmental Protection Agency has really dragged its feet for years in terms of trying to assess the risks of medical waste and determining what the problems may be. I am wondering what you can tell us about the State's position on this and what concerns if any, you have on this, Ms. Kilgore.

Ms. KILGORE. Excellent question, I cannot respond with regard to the State's concern at this point. I do not know. There may be people in the room who do know.

I was recently at a meeting with the board of directors of the National Rural Health Association and many of us were discussing medical wastes in the rural areas, what do rural clinics and rural hospitals do with their own medical wastes as we were watching what was happening in the Atlantic.

Chairman WYDEN. Would you say then the Federal Government needs to get you some good information and some technical assistance as to how to begin to deal with this?

Ms. KILGORE. I would certainly think that is definitely a leadership position there. We all play a part in it but it would be nice to see it coming from that end.

Chairman WYDEN. Would any of the other panel members like to comment on this medical waste issue?

Mr. Busch?

Mr. BUSCH. We use incineration for medical wastes, too. We do not send in any to the oceans.

Chairman WYDEN. Pardon me.

Mr. BUSCH. We do not send any to the oceans, we burn ours and we have worked with the EPA, the State EPA to get an incinerator that would meet the requirements.

Chairman WYDEN. That clearly is the best way to go based on what we now know. The problem, of course, is that as we get more and more of these wastes and more and more is incinerated that

raises environmental questions and also there is consideration of exactly what is being incinerated and I am pleased to hear about your efforts and certainly we must work very closely with the hospitals. The American Hospital Association testified at this hearing.

Rural communities are going to get it with both barrels, of course, because there is a lot of talk, not just about their problem but Dr. Wright came from the State health division to the hearing and he was concerned about the possibility that other States will try to ship it to rural areas and to store it in rural facilities.

I think we are going to have to do a lot of digging into this and a lot of research to make sure that we are looking at the best way to do it and you all give us helpful testimony on that point.

Mr. BUSCH. Representative Wyden?

Chairman WYDEN. Yes, Mr. Busch, please proceed.

Mr. BUSCH. On your question on the AIDS testing, I cannot speak for the State certainly but in Baker County, the public health department does offer free voluntary testing for AIDS and it is done on a number system where a person does not even have to give their identity so that issue of confidentiality, I think is being well addressed by the county health department here in Baker and I suspect in a lot of counties, not all in Oregon.

Chairman WYDEN. Mr. Herron?

Mr. HERRON. But it goes down to the point, it is not so much what happens with the test once it is taken, it is educating the clinics because when you come in and schedule a certain kind of test with the receptionist at the clinic, those kinds of things have a way of other people seeing them, that is where the hesitation issue comes in.

We are transmitting AIDS, people are receiving it not only from intravenous needles but from tattooing, or ear piercing, or other areas where needles are used and we have the tools to stop it. We need to put them into effect and educate the people, not only the health care provider.

Chairman WYDEN. Well, I think your comments are very commendable. Obviously, any approach that uses numbers and things of this nature is an effort to deal in a sensitive way with the fact that people are reluctant to come forward if they feel that the information is going to get out and at the same time I think Mr. Herron has made a point that all of us would identify with is that if the town is tiny and you go to visit the receptionist, regardless of any kind of number system, folks are talking over coffee or something like that. There would be a concern that there would be exposures.

I admire the way you are trying to handle this and recognize that there are some things that the Government ought to be trying to do to try to get these educational materials and assistance out to rural communities.

A couple of other questions I had.

One is for you, Mr. Busch. Have you done a comparison of what Medicare payments are for a service here in comparison to what they are in an urban area? Have you taken, say, a particular procedure, take hip replacement or something, in a rural area as opposed to an urban area in Oregon?

Mr. BUSCH. Not recently. When the system first started it was based on an acuity factor that the level of acuity, they felt the hospital determined the rate of the DRG payment and that has pretty much stayed in place for the last four years but I have not done that in several years.

Chairman WYDEN. There is no doubt in your mind that if you were to take a number of the basic procedures, the rate would be higher in an urban area than it would be in a rural area?

Mr. BUSCH. Just on the wage differential alone it would reflect it there.

Chairman WYDEN. That is your belief as well, Ms. Kilgore?

Ms. KILGORE. Absolutely. The national association has done a number of studies and the percentage of differential between urban and rural DRG prospective payment things are as high as 40 percent. There is no question.

Chairman WYDEN. One other question for you, Mr. Busch. As you know there is a great deal of discussion about the idea of a severity of illness consideration built in to the hospital reimbursement system, the DRG system.

My sense is that something like this could really be of some help to the rural facilities because with the rural facilities, based as you said on a lot of older people, a lot of older people who are quite frail and quite sick that they may be sicker in terms of some of these particular procedures than others in other parts of the State and that if we could get a severity of illness criteria built in to the DRG system, that would really help the rural hospitals. Would that be a view you would share?

Mr. BUSCH. Yes, sir. I know many of our patients have multiple problems when they come in and they come in for an appendix removal, they may have heart disease, high blood pressure, a variety of factors which may keep them an extra four or five days under care.

From what you are describing, I think that would certainly help.

Chairman WYDEN. We have a lot of work to do to get it but it sure seems to me to make some sense that if you are going to have this system of categories, within a category some illnesses are more serious than others and if we could have recognition and consider the severity of an illness, that might really be of some help in a rural area. There are a lot of older people who tend to be quite frail and ill and hopefully, we can get that off the ground.

Mr. BUSCH. With multiple diagnoses when they come in, the DRG system is predicated on the principal reason for admissions, and yet there may be four or five factors that have to be treated simultaneously.

Chairman WYDEN. That really relates to the point Senator Timms and Mike Nelson, I think as well, were talking about which is having a little more flexibility in the system. I mean the DRG system both with respect to severity and the notion that you are not just one category. I guess, what is it, about 460 procedures and what you are saying is you are not just one category. You have multiple categories and the flexibility to have a hospital reimbursed for several different conditions is a sensible one as well.

Mr. BUSCH. As an example, we treated a simple admission, I believe it was either for an appendicitis or an appendectomy or some

basic problem like that and the patient, during the visit to the hospital, had a heart attack but that was not the principal reason for the admission so the person was essentially in the ICU for five days with no reimbursement to the hospital.

Chairman WYDEN. One other question, Mr. Everson, what type of care can a Level I EMT administer?

Mr. EVERSON. Pretty basic care, really. You need to get to Level II and above to administer IV's or drugs of any kind. That is why we offer basic life support service here mainly because our personnel are trained to EMT I Level.

Chairman WYDEN. I am trying to think out loud again about stretching the resources and making the dollars go, do you think your people would be in a position to deliver more extensive life-saving care if the system was a little more flexible?

Mr. EVERSON. Certainly, and we are working on areas to increase the training right now but I think these are some of the areas in emergency health care that need to be addressed in an overall plan like this.

Chairman WYDEN. Would a lot of your people who deliver a Level I, even without additional training, just at this point, do you think they would be in a position to do a little bit more if the system would let them?

Mr. EVERSON. Probably, and in some areas right now, there is some flexibility. They have come out with a "smart defibrillator" they call it, that EMT I are allowed to use. In other words, they do not have to make a judgment whether to administer shock or not, the machine does it for them and so in areas like this, there is some flexibility.

Chairman WYDEN. I do not profess to be a big authority and I want to get more information on it but it seems that if your folks have the training and have the skill, we ought to let them use it in every way possible rather than have various arrangements that in some way restrict them.

It is critical that they have the skill because you cannot have people without adequate skills trying to deliver services that take those skills but at the very least, the Government ought to make sure that if someone has that particular training, we do not restrict them when there are inadequate resources out there.

Hands are up and we are happy to hear from you.

Mr. HERRON. I would like to coattail his remarks on that a little bit if I could.

We have to send our doctors or physician's assistants a lot of times with the ambulance and the fire department and if the EMT's—and the doctors know what the capabilities of those people are but they also know what the legal liabilities are and if they were allowed to do more things, we would be able to keep the providers in providing the basic care more frequently. We spend a fair amount of time with our providers on the road on ambulances.

Chairman WYDEN. Mr. Busch.

Mr. BUSCH. Two quick comments, Representative.

I have met with Don and Mr. Wright, the city manager and Dr. Hoffman this summer to try to work together a plan to develop training for Level EMT II. The Baker County Medical Society in

this county has agreed to work with the city to try to provide training resources to get Level II capabilities.

The other concern that I would see for someone not certified to Level II doing Level II functions is the liability issue if anything went wrong and I think the cities would be very cautious about that and probably rightfully so.

But I think, and again this might be an area for some Federal support in the future or guidelines but local hospitals and local fire departments or ambulance companies working together, I think can accomplish the same thing with a plan or format.

Chairman WYDEN. There really is not a plan to stretch the trained individuals and the resources in the emergency area, is there?

Mr. BUSCH. And its liability is a big factor even if the capability is there if the certification is not, then there is a problem, you are going to lose in the courtroom.

Chairman WYDEN. Ms. Kilgore, I wanted to ask you that for the record. Is there a plan in place now to try to stretch the resources in that State emergency area?

Ms. KILGORE. I am not totally aware of the State's plan. I know that we have been doing a lot of work on the trauma system and developing trauma plans but Oregon is not atypical from any other State in the country where emergency medical dollars have not been available. They are so minimal and certainly the Federal effort for emergency services that was in the early seventies got everything started and then turned it over to the States.

In the urban areas you can deal with it because of volume and dollars but certainly not in the rural areas and the emergency medical system is in real critical shape. I mean it is a whole arena that we could expound on at length, I can assure you.

Chairman WYDEN. I would like to work with you on that as well and did not come today to go into that in great detail but my sense is that it may be another area where we can stretch our resources and the idea is to get more training to people and when they get more training that the Government really let them use it based on their professionalism.

You all have been a very good panel. I would ask questions all morning if I had more time.

Thank you and we will excuse you at this time.

I would like to welcome Pat Gardner, director of Visiting Health Services, Mid-Columbia Medical Center, The Dalles, OR; Dennis M. Bruneau of the Gilliam County Medical Center, Condon, OR; Kathleen B. Mallory, director of nursing, Harney County Hospital, Burns, OR; and Dr. Robert M. McKim, M.D., Baker Clinic, Baker, OR.

We thank you all and we are already running over budgeted time so if you could summarize that would be very good and your prepared remarks will be part of the record.

TESTIMONY OF PATRICIA GARDNER, R.N., DIRECTOR, VISITING HEALTH SERVICES, MID-COLUMBIA MEDICAL CENTER, THE DALLES, OR

Ms. GARDNER. Thank you, it is a privilege to be here to represent the home health agencies especially in the rural areas.

I am a director of a home health agency that covers three counties in the State of Oregon. We have been in effect since 1978.

In our last fiscal year, we made 4,051 visits and traveled 76,696 miles to deliver those services. Our labor statistics show that we require 3.36 hours per visit which includes administration time, direct patient care, travel, paperwork, as well as education. As indicated, the average miles per visit is 18.9. There is no extra charge to the patient for time spent traveling. The per visit charge that Medicare allows through the services, that is nursing, physical therapy, home health aides, occupational and speech therapy amounts to $68.55. The average travel time per visit runs at least 30 minutes. The employee is then in the home for one hour per patient on the average. An additional hour is spent on paperwork related to that visit. This translates into a direct cost per visit of at least $40 leaving $28 of the Medicare reimbursement to cover secretarial time, all other overhead costs for an office, and any contributions to hospital's bottom line.

With acute care becoming increasingly necessary actually related to the DRG reimbursement it is necessary for our staff to be on call for 24 hours a day. On the average of five days a week, that averages 2 shifts a day and on the weekend, that is 3 shifts per day.

By the time staff benefits, overtime, weekend differential is added, there is little left over for lights, papers, office space, and so forth. So the current figure may cover some direct costs but certainly does not cover the indirect costs of providing those visits.

I did a cost comparison on some of the visits that we make to patients as opposed to what a nursing home would be charging for the same amount of time. I will give you three of those examples. We have a lady that lived in Maupin which is an 84-mile round trip. She had skin ulcers that required wound care. Over one month, five visits or $342.75 was charged to that care as opposed to one month in a nursing home which would be $1,927.50.

Most of our training as you can imagine is in teaching the client and the care giver in the home to work in our absence since we are only there on a visit basis.

Another lady living in Tygh Valley, which is 60 miles round trip suffered a sarcoma that required amputation of the leg above the knee and required both nursing and physical therapy visits over a 4-month period, a total of 19 visits which was $1,302.45 as opposed to a 4-month nursing home stay of $7,710.

So it is cost effective to provide home health to the clients in their home.

[Ms. Gardner's statement may be found in the appendix.]

Chairman WYDEN. Thank you very much, Ms. Gardner.

Mr. Bruneau?

TESTIMONY OF DENNIS M. BRUNEAU, PHYSICIAN ASSISTANT, GILLIAM COUNTY MEDICAL CENTER, CONDON, OR

Mr. BRUNEAU. I will try to be brief, thank you.

I think there are many factors that are affecting the access of rural health care in Oregon and in the United States but I tried to focus on two elements that I think are most overriding of all. One is the reimbursement problem and another one is funding of clinics. I believe I have a solution to some localities or some communities that may find this option viable.

The average per capita health bill is $1,900 but for people over 65 it approaches nearly $6,000 and it has been shown by statistics that there are more senior citizens in rural areas, percentagewise, than in urban areas.

The Medicare reimbursement system for PA's must be certified under the Rural Health Clinic Act. The clinics must meet stringent criteria to become certified. They are not given any prospective technical or administrative assistance in how to become certified. They are given a check list to go through and they must develop their own model which many clinics or many communities do not know how to do.

Once they are certified through an arduous inspection they are given a fixed rate fee for each Medicare-eligible recipient they see.

I think that this reimbursement system for rural health clinics that are staffed by PA's and nurse practitioners is not adequate. Physicians, by contrast, are reimbursed for a percentage of their services and do not have to meet the stringent criteria that PA's and nurse practitioners must meet.

I understand that early in 1989 there is going to be a change in the reimbursement for physician's assistants in rural clinics and I understand it is going to be about 85 percent of what a physician customarily charges. Although this is an advance in the right direction, I think it is not adequate because PA's particularly must have physician's supervision and maintain this quality assurance relationship with a physician and this adds to cost.

I think the services are comparable and that I think it is only fair that PA's and nurse practitioners be reimbursed at the same rate as physicians which I feel should be at least 100 percent of what care has been delivered particularly in the rural clinics.

I do not think that you are going to get practitioners in the rural clinics unless there is a better reimbursement system. People are not attracted to rural areas because of the economic problem.

One of the ways to get clinics funded is through the health district concept. Oregon has an excellent law which allows the forming of health districts in this State. There are roughly 28,000 special districts in the United States but there are only two health districts in the Nation, one in Stickney, IL, Condon, OR being the second, and there is a third one in process in Ajo, AZ.

I think making health district legislation more widely known and developing more districts to serve as models, finding funds to pay for start-up costs and technical assistance in enacting adequate allowable rates for taxations will be essential if the health district concept is to fulfill its great potential for financing primary care in underserved areas.

In an era of shrinking Federal participation and health care for the medically underserved areas, the health district concept is viable and warrants serious consideration. I think that the Federal Government should help States that have this legislation or have this law and help with technical means and in some instances where communities are willing to take their own responsibility in providing monies to build clinic or remodel a facility so that they can have a rural health clinic, in that way I think they can continue with their own determination and the Federal Government would not be continuing to pump money into the program.

[Mr. Bruneau's statement may be found in the appendix.]

Chairman WYDEN. Well, thank you and I note with special pleasure that you were the Rural Physician Assistant of the Year last year.

Mr. BRUNEAU. This year.

Chairman WYDEN. This year. Great, you are the current holder of the crown and we appreciate your coming. I think your suggestions were very practical.

Ms. Mallory, please.

TESTIMONY OF KATHLEEN B. MALLORY, R.N., DIRECTOR OF NURSING SERVICES, HARNEY COUNTY HOSPITAL, BURNS, OR

Ms. MALLORY. Good morning, Congressman Wyden.

I am Kathy Mallory. I am the director of nursing service of Harney County Hospital in Burns, OR.

During the past year, there have been many changes across our State in the area of health care. As a director of nursing in a rural hospital I have become concerned about the problems which are facing hospitals throughout the State of Oregon.

Rural hospitals in our State play a vital role in the health status, access to health services and economic well-being of the citizens of the communities within which they serve.

Today, rural hospitals are experiencing a wide scope of problems relating to lack of physicians, lack of capital, lack of diverse services and planning, declining in-patient use, and old existing facilities all of which has forced some to close their doors.

But it is also important that we identify national trends which are impacting health care. One of the most critical problems facing hospitals today is the nursing shortage. The rural hospital faces an ultimate challenge in the education, retention, and recruitment of one of its most valuable resources, the nurse.

Traditionally, nursing has been viewed as an occupation requiring people who care and that is still true today but with the daily advances in medical science, the nurse's job has become increasingly complex and demanding. Nursing today still requires a caring heart but it also requires a professional with a thorough understanding of the latest advances in health care.

The scope of practice for a registered nurse in a rural setting covers medical, surgical, maternity, intensive and/or cardiac care, and emergency room. A colleague in a larger hospital may only be assigned to one of these units and thus become specialized within the nursing profession. Because nurses are licensed and are respon-

sible for human lives, you can understand the immense responsibility that a rural nurse must face in a rural hospital.

It becomes a grave responsibility of the hospital to help the nurses in their facility to stay abreast of the current trends in order to practice their profession. Today most rural hospitals have a limited amount of dollars allocated for inservice training, seminars or college courses. Because of the facility being isolated, it is usually difficult for a professional nurse to have access to programs without incurring expenses for mileage and lodging besides tuition.

Retention of the professional nurse has become an area of concern. Comments heard from nurses concern a level of frustration in not being able to take care of patients adequately, lack of positive feedback and support, little respect from doctors and management, and comparable pay. We need to be creative in looking for ways to keep the nurses we have already working in our facilities.

Recruitment of professional nurses is critical to many of the rural hospitals in Oregon today. Many of us are facing a crisis. It appears that part of the problem is that because of the wide scope of responsibility, it is a very difficult transition for a new graduate to acquire the degree of orientation needed for her or him to accept the responsibility of registered nurse.

Once again, a preceptor program would furnish this needed support but one needs the manpower plus a certain amount of capital for the program to be successful.

Also, it becomes apparent that isolated areas do not offer the best incentives for the professional nurse to establish a residence let alone have the opportunity of employment for a spouse to ensure the stability of the family unit. It is apparent that some of the smaller communities are having economic problems within their own structure and therefore cannot offer sufficient employment opportunities for incoming population.

It appears that we need to address the problem of education, retention, and recruitment of nurses to rural hospitals in order to continue to provide the quality of care now being delivered by rural hospitals to the members of their communities. It is imperative to the rural communities that in most instances, the rural hospital survives. If that vital link of delivering health care to the community dies, so shall the rural community.

What we have going for us is that most nurses out there do care deeply about delivering quality care to their patients. These nurses are keeping patients alive every day. Their contributions may go unheralded but the health system would be lost without them.

Yes; rural hospitals do need nurses and we need to solve the problem now.

Thank you for giving me this opportunity to represent the nurses in rural Oregon.

[Ms. Mallory's statement may be found in the appendix.]

Chairman WYDEN. Thank you very much for an excellent statement.

Dr. McKim, please.

TESTIMONY OF ROBERT M. MC KIM, M.D., BAKER CLINIC, BAKER, OR

Dr. McKIM. Thank you. As you may know I am a last minute fill-in for this position.

My mind reels with everything I would like to say. I have tried for several hours to find a way to put an attention-getting message together. If you have any questions during my presentation or for clarification, please stop me at any time.

Why do people move to or from an area? There are many reasons but among them are jobs, the environment, schools, or health care.

Rural physicians are retiring early, moving, or they are frustrated with their jobs and are currently not being replaced. Few or none of the recent Oregon Medical School Health Care graduates have moved to non-urban areas.

I would like to tell you some of my own experiences. For continuing medical education, I'm required to get 150 hours every 3 years. To obtain this, I must travel to Portland, Seattle, or Boise, not merely across the street or across town. My liability insurance is the same as any other physician with my training in Oregon and you have already heard some of these concerns. You have also heard of the urban/rural differential in reimbursement. In my own practice I have had a partner who prematurely quit because of the frustrations of practice, mostly in the area of bureaucracy. I am in an active long standing practice that has been in existence for over 50 years. But because of liability insurance, decreased reimbursement, increasing paperwork, and regulations it is now of marginal viability.

I would like to use my obstetrical practice to explain some of this. I feel I am qualified to do so after delivering babies for over 22 years and I have delivered over 1,800. In the past I would deliver between 80 and 100 at a cost of $300 to $350. I enjoyed this very much and I did make some money doing it. Recently I am limited to between 30 and 40 deliveries. This costs the patient $1,000 each. It is frustrating to me and it is a break-even financial proposition.

I continue to deliver babies, however, because I feel that it is a community and hospital necessity. I also feel it is a part of total family care. With the invasion of Federal Government and insurances into health care, the administrative costs for care are now in the area of 50 percent of the total medical costs. These administration costs are without any accountability.

I would suggest that an evaluation of health care costs be divided into clinical care costs and the costs of administration.

As most people here, I love this area, this community and these people. I enjoy my work and I feel I do a good job. I am willing to accept the responsibilities of professional isolation, to travel for my continuing education and the long hours required.

Speaking for myself, I believe for Baker and probably most of rural America, we are in trouble. Without doctors there are no hospitals, without hospitals a community will die. Few people are willing to move to an area and stay without a hospital.

Baker County has the second highest over-65 population in the United States, second only to Dade County, FL. Yet, we have nine

physicians to take care of that 16,000 population and I believe Multnomah County's ratio is 1 to 250.

Are you comfortable in supporting these concerns in Washington, DC? If not, what more can we do?

[Dr. McKim's statement may be found in the appendix.]

Chairman WYDEN. I am here because I wanted to listen. That is what we wanted to do here is get people's views and get people's thoughts.

Let me try to follow up on some of the points that were made.

First, with respect to the nursing issue, one of the things is that in that legislation I wanted to do my very best to get some of the demonstration projects to come to rural parts of the State and that is what it really does is fund some demonstration projects so I hope we will get that bill passed in this session.

I think we will be able to and that is one of the reasons that I pushed it hard in this session is that I think it really will give us a chance to try out some new approaches in rural area nursing, Ms. Mallory, so we can look to that specifically.

With respect to your comments, Ms. Gardner, I gather that you believe that the home health care service has become particularly difficult in the last couple of years. Are there some changes that have produced that? I talked about the cut-backs that seemed to have been made administratively in home health care. Maybe you could comment on that.

Ms. GARDNER. I can give you an example that has occurred recently. There are some mandates for standards for home health care and in metropolitan areas, if you have someone sent home, for instance, on an infusion pump you are supposed to know how to use that pump.

In a metropolitan area you have facilities and nurses who are accustomed to using that pump all the time, but when you come to a rural area, in order to qualify for my nurses to take care of those patients, we all had to go to the patient's home when she got home with an inservice directly on the kind of pump that they were using in the Portland hospital because the mandate is that if you have not used the pump you do not send somebody out there to take care of it who has not used it.

That is a quality assurance mandate which is certainly necessary but it also requires immediate attention with time that has to be reimbursed for training for all the nurses in order to do that so those kinds of costs have increased.

As far as the mandate for administrative work, it is growing all the time. You spend more time meeting and reading those changes in the rules and regulations in order to adopt them to your agency in the rural area and to carry them out. It is one thing to write it but you have to show proof that you are carrying these things out. So, I mean it is constantly paperwork, paperwork, paperwork instead of actually providing the direct care that all of us would like to do.

Chairman WYDEN. One question for you, Dr. McKim. I am very sympathetic on this question of the administrative costs. I have been meeting with a special little group of the Oregon Medical Association. In fact, we had a meeting on Monday afternoon of this

week to look at ways in which we can deal with the administrative problems.

What are the administrative costs in your practice that the Federal Government could address because I note that your practice is primarily obstetrics?

Dr. McKIM. My practice is family practice, sir, I dealt with obstetrics only as an example.

Chairman WYDEN. What are some of the administrative costs that the Federal Government ought to be looking at in your practice? It is family practice and so you do a lot of primary care.

Dr. McKIM. Yes, sir.

Chairman WYDEN. What are the administrative costs that we could look at?

Dr. McKIM. My office was run by one receptionist for three physicians approximately 12 years ago. Now, in order to comply with the paperwork, I have three receptionists or three people working in the front office.

Our local hospital cared for—it was a 100-bed hospital. The front office was run by three individuals. With the onset of Medicare, Federal regulation it is now a 50-bed hospital. The average census is probably 15 to 18 people and I believe there are over 50 people in the administration aspect of that hospital.

Chairman WYDEN. I will hold the record open on this point so that if you could, please give us some more information about particular paperwork requirements and burdens. I would like to follow those up with you specifically if you can get us some more information on it.

As I said, I have begun this effort with a special group at the Oregon Medical Association. We had a pretty lengthy meeting on Monday afternoon to talk about some of these administrative matters and I am very sympathetic to what you are talking about. There is no question that this burden has skyrocketed.

Frankly, it is a wonder anybody can figure out the Medicare program, providers, seniors, carriers. I get a call every couple of weeks from someone who is in his 30's or 40's who is a lawyer or an accountant, somebody with professional training who will say, "I have been trying to work with my mother's Medicare bills and I can't figure them out."

There is something very wrong when the system has become that complicated and I have great sympathy with the point that you are making on the administrative costs and want to work with you on it.

Dr. McKIM. I will get you some specifics, sir.

Chairman WYDEN. That is good.

Let me leave you with one other thought, Doctor, that is a ray of positive thinking, I guess. As I am sure you are aware and the medical journals have discussed, there is this major new study being undertaken in terms of physician reimbursement. It is known as the Harvard Study and they are proposing something called a relative value system. One of the things that may really help rural areas and people like yourself is that they are going to argue, based on what we have heard, that primary care should get higher reimbursements, that primary care should play a bigger

role. If we could combine that plus getting some administrative relief, maybe we can get you all some help.

Dr. McKIM. I appreciate that, sir.

Chairman WYDEN. Doctor, we thank you.

Dennis, I am not asking you any questions at this point because you said it so very well earlier. Your point about giving physician assistants a broader role makes a great deal of sense.

You all have been excellent. Suffice it to say, we have built a very good record here to argue for significant changes in the way business is done in rural health care and ways in which the Federal Government can be of help.

So I want to thank all of you for your patience. I know a lot of you have traveled a long distance and taken great trouble to be here. It was an excellent hearing and unless you all would like to add anything further, we will excuse you at this time.

The subcommittee is now adjourned.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned, subject to the call of the Chair.]

APPENDIX

TESTIMONY PRESENTED TO

U.S. REPRESENTATIVE RON WYDEN

"RURAL HEALTH ISSUES"

Marsha Kilgore, Manager

Office of Rural Health

President, National Rural Health Association

August 18, 1988

Congressman Wyden, my name is Marsha Kilgore and I have been the Manager of the Oregon Office of Rural Health since its creation in 1979. I am also a native Oregonian and have been working in rural health for the past 14 years. In addition, this year I am serving as the President of the National Rural Health Association.

My testimony this morning is intended to set the stage for what you are about to hear from others over the next two hours. I would like to highlight my comments in two parts. First of all, I will describe some of the major rural health issues and problems occurring throughout the nation. Secondly, I will briefly describe rural health problems here in Oregon and share with you some of the strategies being developed to address some of these problems.

I would like to begin my testimony by referring you to the attached report entitled, "Health Care in Rural America: The Crisis Unfolds," that was recently commissioned by two of the nation's leading groups concerned with health in rural America, the National Rural Health Association and the National Association of Community Health Centers. For the sake of time, allow me to summarize the findings and recommendations outlined in the report.

There is no question that we are facing a deteriorating rural health care system, worsened by a failing farm economy. There is a critical need for

health services, hospitals, physicians and nurses, all problems which have been exacerbated by the steady decrease in their availability.

The high rate of infant mortality is an example of the poor state of health care in rural America. The United States as a nation has declined from sixth to a tie for the last place among 20 industrialized nations in combating infant mortality, and within this country, rural Americans have rates higher than their white and minority counterparts in urban areas. The problem is exacerbated by the malpractice insurance crisis that is forcing family practice physicians out of obstetrical services.

The health plight of migrant workers is also discussed in the report. They are described as an "outsider" group moving from community to community, always far from family and social support groups. To quote the report, "Their outsider status places them at the bottom of the priority pyramid when services are available, and keeps them from finding system access points which are often not well understood even by long-term residents."

Additionally, the report concludes that the health care systems of rural America are inadequate to serve the needs of those who depend on them. Particular problems cited include:

-- 75 percent of the rural poor do not qualify for public assistance.

-- The lack of comprehensive prenatal care combined with problems of poverty in rural areas has led to high rates of infant mortality,

particularly for Blacks who face a 25 percent increase over their counterparts in urban areas.

-- Rural residents have a 15 percent higher rate of uninsuredness than the U.S. average, and a 25 percent higher rate than their metropolitan counterparts. This leads to a cash drain on the rural family: rural residents pay, on an average, 10 percent more of their income out-of-pocket for health care than their urban counterparts.

-- At a time when rural needs for physicians are high, the National Health Service Corps, an important source of physicians for rural areas, is being dismantled.

-- Rural hospitals are closing at a record setting pace.

-- Systems of reimbursement and insurance are geared to high volume areas, often making the cost of providing services to rural areas too burdensome for physicians and hospitals.

-- The nationwide nursing crisis and malpractice insurance crisis are hitting rural areas particularly hard, often leading to the inability of access entry level care.

Recommendations cited in the report to address some of these critical problems include:

-- Reform of health manpower programs and state statutes to more effectively recruit, retain and utilize health care professionals in rural areas.

-- Full funding of the Community/Migrant Health Center and National Health Service Corps programs to assure the availability of care and providers in rural areas.

-- Revision and full implementation of government reimbursement policies to provide equity to rural hospitals, to increase participation in the Rural Health Clinic Act, to foster incentives to attract health care providers to rural areas.

-- Pursuit of public/private initiatives designed to enhance health insurance coverage for the growing number of Americans without health coverage.

-- Development of model legislation and strategies to encourage states to address the malpractice insurance crisis and its negative impact on access to obstetrical services and infant mortality.

-- Development of programs for rural areas to address public health problems such as AIDS, infant mortality and homelessness.

And a final recommendation to continue the current efforts for conducting practical research to assure a solid understanding of the nature and extent of rural health care problems.

Let me now turn to the rural health issues and problems in Oregon which are not at all dissimilar to the rest of rural America.

First, a few facts to set the stage:

-- 50 percent of the total state population is living in rural areas.

-- 11 of the state's 36 counties meet the definition as "frontier" counties meaning there are less than 6 people per square mile in the county.

-- 125,000 Oregonians live in 39 designated rural Health Manpower Shortage Areas.

-- An additional 115,000 migrant and seasonal farmworkers are without adequate access to health care.

-- 36, or almost half, of Oregon's hospitals are classified as rural.

-- 8 of the 30 rural hospitals, also referred to as "essential" rural hospitals, have less than 50 licensed beds and are between 44 and 96 miles from the nearest hospital.

-- There are 25 rural not-for-profit public or private primary health care clinics in the state, of which 17 are solely operated by nurse practitioners or physician assistants.

The number one problem facing rural hospitals and clinics in the state is the ability to recruit and retain rural health care professionals. That includes physicians, nurses, nurse practitioners, physician assistants and other allied health professionals. Other major issues and problems, which others today will provide you with more detail, include:

-- Decreasing lack of obstetrical services and inadequate prenatal care.

-- Increasing elderly populations.

-- Increasing number of individuals without health insurance and who do not qualify for Medicare or Medicaid.

-- Inequity in Medicare reimbursement to rural hospitals and rural physicians.

-- Lack of access to capital for renovation, remodeling or construction of old and outdated medical facilities.

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-- Lack of sufficient resources to support adequate administration and management of health care services.

-- In general, the overall decline in rural economies.

Some of the strategies we are implementing or are in the development stages for addressing these problems include:

-- Continued support for the Office of Rural Health with a focus on providing technical assistance and consultation to primary care clinics and rural hospitals, including recruitment and retention of health professionals.

-- Increased efforts to promote linkages, networks and coordination among the variety of health care services in rural areas to further the development of health care delivery systems.

-- Continued support of the utilization of nurse practitioners and physician assistants.

-- Support for the Oregon Health Sciences University to establish a Rural Family Practice Residency Program.

-- Providing and developing incentives to attract and retain rural health care professionals, such as tax breaks for those practicing in rural areas.

-- Stronger emphasis in the role and relationship of health care to the overall economy of rural areas.

-- Support for the establishment of a state Area Health Education Center program.

-- Efforts to increase coordination and maximize the resources of state, federal and private programs focusing on health care.

In closing, I would like to extend our appreciation for your continued support and interest in rural health issues and thank you for your participation on the House Rural Health Coalition and for further drawing attention to rural health by holding this hearing.

HEALTH CARE IN RURAL AMERICA: THE CRISIS UNFOLDS

Report to the Joint Task Force
of the
National Association of
Community Health Centers
and the
National Rural Health Association

May, 1988

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Introduction

Many of the problems in rural health care are well known. Most policy makers know there is a physician and nursing shortage or that rural hospitals are in financial distress. Unfortunately, much of the research in this area is issue specific and is descriptive of the depth of the problem rather than analytically looking at the interplay of the diverse issues. The issue specific nature of the research then produces a "shotgun" approach to public policy development, when a coordinated approach would be more effective. For example, increasing Medicare reimbursement to rural hospitals to more accurately reflect costs, without addressing the problem of the shortage of physicians in rural areas is to provide the hospital with resources to support the cost of inpatient care without the physicians to provide the care. This report is designed to provide an analytic view of the diversity of issues and is intended to stimulate a coordinated approach to public policy solutions.

The report begins with a description of the nature and extent of the deteriorating situation in rural America. The impact of various issues and trends on several sectors of the rural health care system and different sectors of the rural population are then examined. The report concludes with a set of recommendations that are intended to provide direction for federal and state public policy makers.

This report has been developed over the last year as a cooperative effort of the National Association of Community Health Centers and the National Rural Health Association and in collaboration with other national organizations who share common concerns and goals.

The Deteriorating Situation

The economic situation in rural America continues to deteriorate, increasingly burdening a health care system that has been chronically inadequate to meet the needs of rural Americans. In order to understand the diversity and complexity of the problem, one may look at the following as examples:

In Montana, a young family doctor is giving up his practice in his hometown due to the rising cost of medical liability insurance. His premiums are now $53,000 per year -- more than his net income last year. He could lower his premiums by stopping his small obstetrics practice, but delivering babies is the "joy" in his otherwise sorrowful work. If he can't deliver babies he said he would leave his hometown and go into aerospace medicine. His departure will leave a vast area without ready access to obstetrical services.

In West Virginia, a family of four lives in poverty. The father has been out of work for over four years, no longer qualifying for unemployment assistance or being counted in the unemployment statistics. He was a coal miner, put out of work by new technology. The family is essentially homeless, living in a small, run-down house with no running water or flush toilet. They live on a small public assistance check and food stamps -- nearly 70 percent of the county's population is on food stamps. The state's Medicaid program is nearly bankrupt, so the local community health center is the only place they can go for health services. In other places in West Virginia, accounts receivable from Medicaid and bad debts from people with no insurance are threatening to close some community health centers.

In Missouri, a small town has been trying for over two years to recruit a family doctor to replace their aging local doctor. The town's small hospital is in serious financial

condition, partly because Medicare pays it nearly 40 percent less for its services than hospitals in the city 70 miles away. About 60 percent of the hospital's business is from the elderly. The hospital is having trouble recruiting nurses too, because they don't have the resources to increase wages or expand benefits because of negative profit margins.

In South Dakota, a farm family has hit hard times. They are using every penny to hold off the family's creditors, and they have dropped their health insurance policy as an expendable item. They pray they will not get sick or injured. They are at high risk since farming is one of the most hazardous occupations in America. Their new poverty is causing great stress, and the husband is drinking too much. Help is hard to find because the community mental health center has dropped its outreach into their rural area.

In Colorado, two family doctors have been in practice for two and three years under the auspices of the National Health Service Corps. One doctor is leaving to find a more lucrative, less demanding practice in the city. The remaining doctor will stop obstetrical practice when the other doctor leaves because the load is too heavy for one doctor and the National Health Service Corps has no other doctors available for placement. Over 100 pregnant women per year will have to drive to the next distant town for services. Private recruiting efforts have been unsuccessful for this remote town.

Although one-quarter of all Americans live in rural areas, public funding for health care in rural America has consistently lagged behind the U.S. average. At the federal level, per capita expenditures for health and related services are far lower for rural residents:

- 42 percent fewer health service dollar per capita than the U.S. average
- 50 percent fewer social service dollar per capita than the U.S. average

Programs which combine federal and state responsibility mirror federal expenditure trends:

- *70 percent* of the rural poor live in states where the maximum AFDC benefits are below the national median.

- The rate of qualification for public assistance is 37 percent lower in rural areas, and more than 75 percent of the rural poor *do not qualify* for public assistance.

Current statistics on the 1980s indicate that an ever-increasing demand is being placed on inadequate rural resources. Farm closures, unemployment, loss of insurance, and inability to pay for health care have provided additional pressures on the rural family:

- Since 1979, reversing a historic trend, the rural unemployment rate has been *consistently higher* then the urban unemployment rate. In 1979, 5 percent of the 2040 nonmetropolitan counties had high (9 percent or above) unemployment rates; by 1985, that figure had grown to over 50 percent of rural counties having high unemployment.

- Between 1981 and 1986, 650,000 farms were foreclosed nationwide and in 1987 alone, American families gave up farming at the rate of *2,000 per week.*

- Between 1981 and 1983, rural America lost 500,000 jobs.

- Current estimates are that 35 percent of rural workers are under-employed, either working part-time or in jobs beneath their skill levels.

- Recent predictions based on expanding and contracting areas of the economy are that only *one* job will be created in non-metro areas for every *seven* created in the city.

These trends have placed more rural residents in jeopardy, as loss of insurance and income erode the ability of the rural family to purchase health care. For all races, the median family income for non-metro and farm families is consistently lower than it is for metro and non-farm families. In 1985, 17 percent of all farm families, and 15 percent of all non-metro families, had income below the federal poverty level. For some segments of the rural population, the situation is much worse. As many as 36 percent of rural Hispanic families live in poverty. One of every five elderly non-metro residents lives in poverty, a rate 15 percent higher than for elderly residents of the United States as a whole. The combined result of these statistics shows that rural America, with 25 percent of the country's population, has 38 percent of the nation's poor. At its extreme, the problem is heavily concentrated. Of the 86 counties nationwide in which 1/3 or more of the population is in poverty, all but one are non-metropolitan in nature.

Both employed and unemployed rural residents feel the economic pressure of current trends. Real per capita income in farm counties fell from 91 percent of the metropolitan level in 1973 to only *76 percent* in 1984. All rural residents, as a group, have a 15 percent higher rate of uninsuredness than the U.S. average, and a 24 percent higher rate than their metropolitan counterparts. The low levels of insuredness contribute to a cash drain on the rural family. Rural residents pay, on average, 10 percent more of their income out-of-pocket for health care than do their urban counterparts. Among the poor, those supposedly protected by the "safety net," rural residents experience a 10 percent higher rate of uninsuredness than the U.S. average, and a 44 percent higher rate than their metropolitan counterparts.

The results of this long-standing problem, exacerbated by the economic downturn of the 1980s, may be seen in the health profiles of rural Americans. Rural residents are more likely to suffer from chronic disease conditions, including: arthritis, visual and hearing impairments, ulcers, thyroid and kidney problems, heart disease, hypertension and emphysema. They are also more likely to suffer limitations in activity as a result of these chronic conditions than are urban dwellers.

More hospitals, physicians and nurses, and other health personnel and services will be required to meet these increasing needs. Yet current trends in availability of health care facilities and personnel show marked decreases and consistent inadequacy which paint a bleak picture for rural Americans.

Hospitals

More U.S. hospitals closed in 1987 than in any other year during the decade, with record closures of rural hospitals. According to a recent study funded by the Center for Health Services Research and carried out by the University of Illinois at Chicago, a total of 80 hospital closures were noted during the year -- and 40, or half, of the closures were in nonmetropolitan areas. In contrast, during the period 1980-85, rural hospital closures averaged 20 per year and were only 35 percent of all community hospital closures. Almost one-third of the nation's hospital closures were in Arkansas, Louisiana, Texas and Oklahoma alone.

The increase in hospital closures relates closely to Medicare's implementation of the Prospective Payment System (PPS) in 1984, with over twice as many hospital closings in

1987 as in 1984. Under PPS, Medicare pays rural hospitals 36 percent less than urban hospitals for the same services. As a result, according to the Department of Health and Human Services, in 1986 urban hospitals made a 10.82 percent profit margin on PPS patients, while rural hospitals *lost* an average 0.69 percent.

The pressure on hospitals will have results which place even more pressure on the rural family's income. Predictions by Lewin/ICF, in a recent issue of Medical Benefits include:

- o increased numbers of closures of hospitals, especially in inner cities and rural areas which need them most;
- o increased shifting of higher medical costs to the patient, as insurance coverage falls further behind rising medical costs;
- o decreasing ability of hospitals to meet increasing needs for charity care; and
- o decreasing ability of hospitals to adopt newer technology due to dollar limits on diagnosis-related group (DRG) health care interventions.

In the current atmosphere, proponents of lower health care costs depend heavily on preventive health interventions as a way to maintain good health outcomes while avoiding the increased cost of secondary or tertiary treatment. This strategy depends on access to entry level care, including local physicians, mid-level practitioners, and an availability of other health services which work in a coordinated fashion to manage total care for the patient efficiently. Unfortunately, supplies of such providers, and the existence of necessary comprehensive care systems, are not in evidence in rural America.

Physicians

Many rural communities continue to have problems in recruiting and retaining physicians, despite the alleged national "doctor glut." While some diffusion of doctors into rural areas is taking place, it is very slow and is not occurring uniformly across the country, according to a recent study performed by Kindig and Movassaghi of the University of Wisconsin-Madison.

The study showed that in small rural communities between 1975 and 1985, physician-to-population ratios grew at a rate less than half as fast as in the nation as a whole (14.2 percent compared to 32.5 percent). Moreover, small rural communities continued in 1985 to have physician-to-population ratios less than one-third that of national rates (53 physicians/100,000 versus 163 physicians/100,000).

One of the most important programs to address this problem, the National Health Service Corps (NHSC), is being dismantled after over 15 years. At the very time when rural provider needs are high, the field strength of the NHSC is declining. Nearly 65 percent of Corps placements have been in rural areas. By the end of FY 1989, the NHSC field strength will be only slightly more than half its field strength at the beginning of FY 1988 (from 2,595 in 1988, to 1,401 in 1989). Projections for the following year are that about 800 NHSC scholars will be available for placement in 1990. This pattern, should it continue, will mean that thousands of rural communities will be at risk for medical care, and they will be forced to try to compete with wealthier, more attractive practice settings to fill physician vacancies.

Nurses

The current nursing shortage is the result of numerous trends, including projected reductions in workplace opportunities as health care facilities close, and lowered federal support for nursing education. Nursing salaries have not kept pace with growing professional opportunities in other sectors, and are under increasing pressure due to implementation of general cost-saving measures in the workplace as reimbursement decreases for patient care. Projections by Lewin/ICF in Medical Benefits indicate that 10,000 fewer nurses will graduate in 1992 than did in 1984. The rural nursing shortage may grow even faster than the national shortage, as rural health care facilities with inadequate resources find it increasingly difficult to compete for nurses in the face of increased demand for their services in all settings. This is of particular import to rural areas, given the health status of rural residents and the shifting emphasis to lower cost, primary care in managed care service delivery settings. Nurses, both RNs and mid-level practitioners, form a significant proportion of the front line professional provider staff upon which such a system depends. With increased demand on an already fragile system of rural health care, the nursing shortage will mean lack of any access to entry level care for many rural residents.

Increased Demand

A consistent theme in discussions of rural health care has been the differentially low access to providers and facilities, as well as a lack of some or all of the components of a coordinated care system. Decreased federal funding for emergency medical services has left many rural residents without access to life-saving care in emergency situations. Long distances and provider shortages work to disrupt the smooth passage of a patient up and down the technology gradient when necessary, thus resulting in inadequate communication of patient needs and problems among primary providers, specialty care professionals, and extended care/recuperation resources. Further, resources necessary for successful outcomes following secondary or tertiary treatment are often unavailable. Surgical patients, high-risk mothers and infants, and other high-risk patient groups require consistent medical and health care during the entire course of resolution of their presenting problem. For example, the rural resident who is a victim of a serious automobile accident faces increased risk due to inadequate emergency medical transportation. Even assuming that transportation is available and the hospital treatment is successful, that increased risk is still not ameliorated: necessary intermittent follow-up, nursing care during recuperation, home meals and a safe, clean environment may not be available, especially to low-income persons. Shortages of ambulance services, home health providers, social service agencies and on-site medical/health providers decrease the patient's chance of obtaining the longer term, managed care necessary for positive outcomes. While this is true for all patient categories, it is especially illustrated by four problem groups facing rural providers today.

Medical Liability Crisis

According to a recent issue of Medical Economics, 63 percent of all family physicians and 45 percent of all general practitioners have dropped obstetrical care during the past five years in order to minimize malpractice risks. Medical liability premiums charged by physician-owned insurers increased by 99 percent in Utah, 73 percent in Colorado, 60 percent in North Carolina, 55 percent in New Mexico, 50 percent in Wyoming and 46 percent in Kentucky.

A recent survey by the Kansas Academy of Family Physicians showed that 23 percent of their members have dropped obstetrical services in the past five years citing rising

medical liability insurance costs as a major deterrent. The group's executive director predicted that obstetrical services, especially in rural areas, is headed for a crisis.

A recent unpublished study in Colorado showed that if malpractice insurance continues to increase, the number of physicians providing obstetrical care will decrease, the distance pregnant women must travel and the number seeking care outside their county will increase, and low-income women are again the most vulnerable. Already 21 percent of the state's family and general practice physicians had dropped obstetrics in the past five years, citing concerns over malpractice insurance costs and fear of litigation as the major reasons. Over 60 percent of physicians providing obstetrics care for Medicaid and indigent women said they would drop obstetrics with increasing malpractice premiums. If rates were to rise only modestly to anticipated rates, 66 percent of rural FPs and 47 percent of rural OB/GYNs would drop obstetrics, resulting in thirteen additional counties (32 in all) having no medical obstetrical care. An additional 15 counties would have only one obstetrical provider.

Infant Mortality

Reduction of infant mortality is linked to relief from poverty and access to care. Perinatal care, good prenatal experience, and adequate follow-up are dependent on adequate housing and nutrition, health education, availability of specialty knowledge and competence, access to long-term follow-up by trained professionals, and adequate resources to assure the availability of clothing, heating, and necessary medication. Gaps in the service network and lack of resources would be expected to increase the risk of infant mortality. That is, we would expect higher infant mortality rates in rural populations due to lack of access to comprehensive care, especially in populations with high rates of poverty. In a U.S. population with an overall infant mortality rate of 11.2 deaths per 1,000 live births, we find the following:

Infant Mortality

	Metro	Non-Metro
Black	19.1	19.7
White	9.6	10.0

The above statistics indicate a higher infant mortality rate for rural areas across race. Using fetal mortality for Blacks only, the figures are:

Black Fetal Mortality

All U.S.	Metro	Non-Metro
13.7/1000	13.1/1000	16.3/1000

Non-metro Black/U.S. residents experience a 25 percent higher rate of fetal mortality than their metro counterparts.

The infant mortality rates for rural minorities is horrendous. This factor is now being further exacerbated by the malpractice insurance crisis that is forcing family practice physicians out of obstetrical services. This will only lead to an even higher infant mortality rate in rural areas.

The Homeless

Rural statistics on homeless individuals have been hard to develop, partly due to a lack of statistical data which in itself is a result of the inadequacy of rural resources. Although rural areas have 67 percent of all U.S. substandard housing, increasing unemployment rates already higher than comparable metro rates, and snowballing employer and business failures, homelessness is still commonly viewed as a predominantly urban problem. Disparity in the approach to the homeless problem enabled by recent grants under the newly created Section 340 of the Public Health Law are shown in the table below:

	% of Population	Estimated % of age of Homeless-CA & MD studies	# of Grantees under Section 340
U.S	100	100	109
Metro	75	82	99
Non-Metro	25	18	10

In recognition of the need for a comprehensive service approach to the needs of the homeless, Section 340 of the Public Health Service Law, created by the Stewart B. McKinney Act of 1987, includes primary health care, substance abuse programs, and mental health resources. With fewer resources overall to assure access to health and social services, rural communities have been provided with additional federal dollars, but nonetheless these are obviously insufficient to meet projected needs.

AIDS

The increasing seriousness of the AIDS epidemic has been projected to have devastating impact on Americans and on the health care community which serves their needs. AIDS patients represent an excellent group to illustrate comprehensive care needs, as available and sensitive care is necessary at all levels of the technology continuum. Screening and education, as well as counseling, are indispensable at entry levels to meet the medical, social, and emotional needs of the patient. The course of the disease process alternates between demand for high-technology intervention and longer term-supportive care. The entire system depends on the availability and coordination of resources to provide testing, counseling, education, primary medical care, specialty and hospital interventions, home care, respite, and hospice care.

Very little has been said concerning rural responses to AIDS patients, and few rural areas possess the coordinated patient care system necessary to meet this challenge. Fewer still have the resources to actually create such a local system. While AIDS continues to predominantly impact the urban delivery system, Centers for Disease Control (CDC) statistics indicate that rural areas are facing a growing problem which will further tax their limited resources or force victims of AIDS to move to urban areas, abandoning their existing social support systems and placing additional demands on metro health care services. Fairly consistent CDC data indicates that 20 percent of AIDS cases are rural, an indication that, proportionate to population, the illness is more evenly distributed in metro/non-metro areas than is generally thought. The AIDS syndrome is an extreme test of the national health care system. In rural areas, it will place further and heightened stress on a system already inadequate to meet the needs of a less fortunate population.

Migrant Farmworkers

Each year, more than half a million migrant agricultural workers and dependents leave their homes, enter the migrant "stream," and travel throughout rural America. In many ways, their relative degree of access to health services defines the lower end of the continuum. The general problems of resource and provider shortage, inadequate housing and social services, follow-up/management issues, and poverty are exacerbated for this population of people by the nature of their activities. Within this country, they are an "outsider" group in each community they visit, with family and social support groups far away. In general, their outsider status places them at the bottom of the priority pyramid when services are available, and keeps them from finding system access points which are often not well understood even by long-term residents. Given the nation's ongoing dependence on migrant and seasonal labor illuminated through discussions of the effect of the new immigration law, rural America will continue to face this problem for some time to come, and will need to deal more effectively with access to existing services as well as the problem of care in areas which do not now have migrant health programs available.

Further Issues

To recapitulate, rural areas have long-standing problems in terms of poverty, access to and availability of health care providers, and lack of common resources to assure continuity of care. While the current rural economic crisis has added to the problem, it is by no means a new or cyclic phenomenon. A recent study by Ross and Morrissey (1987) indicates that, while a larger proportion of the nonmetropolitan population is poor, the percentage of nonmetropolitan poor who are persistently poor is about the same as for the metropolitan population. They found that "Over 8 percent of non-metro residents were persistently poor in 1982 compared with 5 percent of metro residents. An additional 14 percent of non-metro and 9 percent of metro residents experience transitory periods of poverty. And, despite the concern about poverty spawning a permanent underclass in urban ghettos, the share of poor who were persistently poor was about the same (35 percent) in both non-metro and metro areas" (Ross & Morrissey, 1987). Thus, while overall metro-non-metro statistical comparisons tend to mask the presence of affluent population segments in urban society, comparisons of the poor and underserved in rural and urban areas clearly show mutually-shared economic and health care access disadvantages.

Moreover, general problems of access to health care in rural areas are exacerbated for minorities and special population groups. Blacks, Hispanics, and the elderly face crushing poverty in areas where care often is more available with increased ability to pay. Moreover, residents of extremely rural (less than 6 persons per square mile) areas, migrant farmworkers, AIDS patients, and high risk mothers and infants experience most sharply the lower end of a continuum of provider resources already attenuated by geographic distances and population limitations. Consideration of rural health problems must involve discussions of both patient issues and provider/resource availability.

Patient Issues

Patient issues include both availability and affordability of care. If no care is available, or if continuity of care is interrupted or poorly coordinated, all potential patients suffer. Interruptions in availability of care and current lack of services are serious problems facing all rural residents, and reasons for availability problems are increasingly economic in nature.

Regardless of improvements which might be made in availability of care, affordability will remain a separate but related issue. Especially in rural areas of the United States today, if you are Black, Hispanic or elderly, you should avoid illness at all cost. The ability of poverty populations to obtain health care in rural America, as demonstrated by differential morbidity and mortality data, is so restricted as to make rural residence alone a clear health danger to the poor. And for those already ill or at risk, rural residence is an even greater threat. High risk mothers, high risk infants, AIDS patients, elderly Americans with chronic health problems, accident/trauma victims, and others for whom communication along the health care system and access to secondary or tertiary care providers is important should not live in rural areas.

Providers/Resources

If you can afford to live in a rural area and pay for ongoing health care, the provider of that care may not be able to afford to treat you. Our national system of reimbursement is constructed on volume and averages. The DRGs which drive hospital reimbursement today are based on average care. For some illnesses, a given patient may require three days of hospitalization or seven days, and the reimbursement is capped at five days. In a large hospital which sees many patients with that illness, over time the number of patients requiring three or seven days will even out, and patient flow may begin to approximate the distribution on which the payment cap is calculated. In a small community hospital which may see only half a dozen such cases per year, the patient flow has no chance to approach that distribution. If all six patients, by chance, happen to require seven days of care, the hospital loses money. If similar conditions hold across all diagnostic groups, the hospital is in serious trouble.

Life-saving technology, a high cost option, is also spread across volume of patients. A price of equipment which costs $500,000 and is used to treat 50,000 patients during its effective life is less costly per episode then if it is used to treat only 10,000 patients.

Similarly, an obstetrician who assists in the delivery of 250 babies each year, paying the same liability insurance premium as an obstetrician who makes 100 deliveries, is more likely to be able to spread the cost of that insurance across patients without placing the cost of delivery outside the reach of some patients. In rural areas, a family practitioner who is trained in uncomplicated obstetrics may have been the only resource available last year. In 1988, such a provider, looking forward to only 20-30 deliveries, cannot afford to provide obstetrics due to insurance cost alone; at 25 deliveries per year, a $25,000 insurance policy becomes an unacceptable overhead expense.

Equivalent arguments can be made for the availability of health services along the entire spectrum. Rural communities are forced by scare resources to choose between necessary services. In very small communities or sparsely-populated areas, the people may be forced to do without health services altogether.

Directions for Consideration

Discussions of response should be designed to increase affordability and access to care for rural residents. Two approaches should be used in concert: assuring care for poverty populations while working to strengthen the health care system in ways which ensure that comprehensive health care can be accessed through entry points in rural areas. Several approaches have been and are being used by the federal government and state/local officials to encourage access to affordable care for rural residents. They include

Community/Migrant Health Centers, the National Health Service Corps, Certified Rural Health Clinics, and hospital transition legislation, as well as discussions of equitable reimbursement for rural providers based on a re-examination of the original reasons for a rural/urban reimbursement differential. While some of these approaches are quite recent, many have a history of service which deserves re-evaluation with an eye toward improved services.

Community Health Centers

Community Health Centers grew out of the old OEO programs. Initial forays into rural areas occurred 20 years ago, under Health to Underserved Rural Areas (HURA) grants and Rural Health Initiative (RHI) grants. All remaining such grantees are now incorporated under Community Health Center (CHC) policies, with the same administrative guidelines and reporting requirements as all other CHCs.

Originally, funding for HURAs and RHIs provided more flexibility in areas of governance, clinical care and administration than permitted by CHCs. This same flexibility extended to the number of services provided. It was thought that rural programs could be operated with fewer services, and lower grant dollar levels, than larger health centers. At baseline, rural centers were typically smaller sites, with fewer providers, lower grant dollar funding, and fewer services. Typically less funding and effort was directed toward dental services, pharmacy, social services, preventive health education, transportation and outreach. An assumption made by such centers was that those services could be developed during the center's growth. But that has not proved possible. In fact, funding for all health centers has not even approached the increased costs of service caused by inflation alone. The current three year funding freeze, in fact, has threatened the existence of allied health services even at larger centers. In terms of rural needs, and the lack of other resources discussed above, both the theory of rural center establishment and the continued low level of funding have been in opposition to documented trends. Higher levels of authorized funding are necessary, even for those centers which exist, to meet rising costs and the increasing demand for services to the medically indigent caused by the rural economic crisis. Even more money will be necessary to permit expansion of this much needed program into other rural areas which currently lack services.

Certified Rural Health Clinics

The law permitting certification of rural health clinics is 10 years old. Low reimbursement caps have driven many such clinics to request decertification, and discouraged others from applying for certification. A program which was meant to increase flexibility of rural services, including payment for home visits and visiting nurse programs, while maintaining cost effective local provider access through use of midlevels, has withered on the vine. Congress predicted that approximately 2,000 clinics would be Certified by 1990, but there are only about 400 Certified Rural Clinics today.

And while the cap on reimbursed costs has finally been raised, administrative regulations and lack of knowledge about the legislation remain barriers to maintenance of existing clinics or establishment of new clinics. More work needs to be done to facilitate the ability of rural providers to obtain and maintain Certified Status.

National Health Service Corps

The NHSC has been discussed under the physician shortage heading. it should be noted that great need still exists in rural areas. Dismantling of the NHSC is a real blow to such communities. Several approaches to this problem have been discussed, and one or more federal/state incentives to rural practice will remain necessary for the foreseeable future if rural Americans are to be able to access the care they need.

Hospital Transition

Rural hospitals face double jeopardy. Current inequitable reimbursement by Medicare, combined with low utilization, threaten the existence of hospitals in many rural areas. Transition of the hospital to a different facility that would continue to provide care to rural residents is not currently facilitated by either legislation or adminstrative policy. Efforts to provide that facilitation are occurring at the federal legislative level, but model state legislation and changes in federal/state administrative regulations are immediately necessary, as are changes in the DRG reimbursement formulae to recognize rural disadvantages in current regulations.

While no easy answer to the rural health care crisis exists, specific initiatives as listed below would provide an initial attack on the problem from several directions. They include:

Given the ever-increasing shortage of health manpower in rural areas:

- Congress should fully fund the National Health Service Corps Scholarship and field placement programs as well as the Loan Repayment program in order to place urgently needed health care professionals in rural areas.

- States need to take a serious look at reforming their existing health manpower programs to more effectively place health professionals in the neediest areas and ensure their retention over time.

- Federal initiatives to states should be developed which would encourage states to adopt/reform health care practice statutes to allow for appropriate use of mid-level practitioners in primary care settings.

- Federal and state reimbursement policies should foster incentives to attract and retain physicians and other providers in rural areas.

- Federal efforts to market and provide technical assistance to enhance the number of Certified Rural Health Clinics should be developed.

Given the increasing number of uninsured rural residents and the lack of access to basic health care:

- Congress should reauthorize Community and Migrant Health Center programs at levels of funding sufficient to enable current centers to meet necessary costs and provide for new centers in rural areas unserved at present.

- Federal and state public officials should pursue private/public initiatives designed to ensure that Americans without health insurance are provided basic health coverage regardless of ability to pay.

Given the increasing crisis in malpractice insurance and its impact on access to obstetrical service and, ultimately, infant mortality in rural areas:

- o Model federal legislation as a guide to states now struggling to address the threat to service posed by rapidly increasing malpractice insurance costs should be developed along with incentives for states to address this problem.

Given the financial crisis facing many rural hospitals and the increasing number of rural hospital closures:

- o The Medicare program should replace the separate urban and rural DRG rates with a single rate for all hospitals adjusted for legitimate and current local cost variations.

- o The current wage adjustment in the Medicare DRG reimbursement formula should be refined to more accurately reflect the cost of professional labor for rural hospitals.

- o Federal and state public policy, reimbursement strategies and health care regulations should be designed to encourage hospitals to diversify and engage in a smooth transition to health service facilities tailored to address the unmet health care needs of the local area.

Given the increasing prevalence of public health issues such as AIDS, infant mortality and homelessness in rural areas:

- o Flexible federal/state assistance for these public health problems should be designed to ensure programs are both responsive to the unique characteristics of rural areas and funded sufficiently to allow for flexible approaches.

- o While acknowledging the importance of research, assure that federal AIDS initiatives emphasize the necessity of community education, outreach, prevention and early diagnosis and treatment for victims of AIDS.

- o States should embrace the options provided under federal legislation in recent years which would enhance the number of women and children eligible for Medicaid coverage in order to assure early access to health care and reduce infant mortality.

- o Congress should provide sufficient appropriations for the federal Health Care for the Homeless program to include provision of services to homeless people in rural communities which received minimal health care support during the first year of the Program.

- o Congress should ensure that homeless women, infants and children are eligible for the WIC program in all states.

Given that the priority public policy direction is focused on the needs of the rural health service delivery system in crisis, it is also recognized that practical research is necessary to assure a solid understanding of the nature and extent of the rural health care problems. Therefore:

- o There should be continued funding for rural health research centers through HRSA's Office of Rural Health Policy.

- Additional funds should be provided to the National Center for Health Services Research to support studies on rural health services based on the research agenda developed last year under a Congressional mandate.

Some of these recommendations would improve health care for both urban and rural populations given the fact that rural populations and urban poverty populations share common problems. While it is not likely that rural populations will move *en masse* to urban areas, it is probable that increasing numbers of high-risk segments of the rural population will seek necessary but locally-unavailable care by traveling to the city. Such a migration of problem patients, including poor minority group members, AIDS patients, or high-risk mothers has already been seen in some areas. This places additional burdens on that portion of the urban health care system which deals with uncompensated care, at a time when it can least afford such an increase. Rural residents and urban uncompensated care or medically-indigent populations have similar problems. They can and should work together to effectively advocate for policy changes of mutual benefit. Medically-indigent urban residents also face provider shortages, facility closures, and inability to maintain access to care in the face of rising costs. Common interest indicates that workable policy decisions be sought by working together toward a goal of improved health for all Americans.

TESTIMONY BEFORE THE U.S. HOUSE OF REPRESENTATIVES
SMALL BUSINESS COMMITTEE
SUBCOMMITTEE ON REGULATION AND BUSINESS OPPORTUNITIES
Baker, Oregon,
August 18, 1988

I am John Kendall, Dean of the School of Medicine, Oregon Health Sciences University. Thank you for the opportunity to testify before your hearing. Dr. Peter Kohler, President of the University, was not available due to a previously scheduled activity, but extends his greetings and his special interest in providing assistance from the Oregon Health Sciences University in resolution of the difficult problems facing practitioners and health care facilities in rural Oregon. He has made it among his top several priorities to begin to address those issues in a proactive way at the university.

We at the university share your concern about the adequacy of health care facilities and providers in rural and remote areas throughout the United States, but of particular concern to us are the rural and remote areas of Oregon. We recognize the plight of the small hospital in maintaining open doors with a relative small number of patients and the plight of the practitioner who is called on to provide an ever increasing complexity of service with limited numbers of staff and the emotional and physical limits of the practitioner.

The maintenance of health services in rural areas is complex, involving a host of social and economic issues as well as direct health care. We have been considering these issues for some time and our interests range from mechanisms to attract potentially interested students from rural areas into health care education to provision of expanded continuing medical education offerings for the experienced physicians and other health care providers in the field. Today we wish to focus on three specific areas of potential activity in which we

believe the university could be of special help in meeting shorter and longer range needs.

The first concerns what we believe is a unique proposal. It is well understood that many of the rural and remote communities face problems in attracting family physicians who are sufficiently broad in scope and in training to manage not only the daily common disorders but also the relatively complex problems that because of time and remoteness they must handle. The newly trained family physician, while very well equipped to handle a broad range of problems and disorders, may be less able to assume the spectrum of responsibilities in a rural remote hospital. The family physician in an urban setting may call upon an array of specialists to assist in complex situations but the practitioner in a remote setting must be prepared to render care without such immediate assistance. We believe it is feasible to address the preparation for the special problems of practice in remote areas by the development of a model program for training of the family physician beyond the ordinary three years of postmedical school education. We propose two years of family medicine fellowship for those individuals who intend to undertake rural remote practices. Such a fellowship would include training segments in high risk and operative obstetrics, trauma care, intensive and coronary care, expanded periods of training in gynecologic and general surgery. These training segments would be interspersed with rural preceptorships so that some of the experience can be applied first hand and thereby provide additional immediate relief for practitioners in some of those communities. The model program concept has been developed by our Department of Family Medicine in the School of Medicine at the Oregon Health Sciences University and we are prepared to discuss costs and other details of the program should you desire.

Another important activity which we wish to embark upon is the development of an Area Health Education Center program. This is a federally sponsored program which has been widely engaged in by many medical schools and affiliated communities throughout the country. Oregon does not have an AHEC. Such a program provides the opportunity for students and other trainees to engage in firsthand rural health care experiences under the auspices of a medical school and its affiliated professional schools. For Oregon to be participatory in such a program requires expansion of the program at the national level. We hope that the authorization and appropriation for the AHEC programs will be sufficient to allow Oregon to compete for such a program in the future. President Kohler and the faculty of the university have already had prolonged discussions about our involvement and, indeed, have begun to explore possible arrangements in an Oregon community to develop such a relationship. Further development, however, is dependent upon federal, state and local support for its long term viability. We are appreciative of your efforts in following the Area Health Education Centers authorization legislation so that it may be possible for us to be included.

A third area of interest concerns an evaluation of the present reasons for the attractiveness of some communities for physicians and other health care practitioners. We at the Oregon Health Sciences University are working in conjunction with other elements of the State System of Higher Education, particularly health planning and governmental studies groups to evaluate the reasons why certain communities have made themselves especially attractive to health care providers. We would hope to identify those features which could be utilized by other communities to enhance their own attractiveness. While it is widely known that there are commercial entities available to assist in making communities more attractive and studies of this have been conducted in the

past, we believe it is timely for Oregon that the information be updated in view of the present concerns and lack of specific knowledge about the breadth and depth of these issues. We will work to obtain this information with other universities and colleges in the State System of Higher Education and other agencies including the Office of Rural Health programs.

We believe that a multifaceted approach by the university in conjunction with concerned citizens will provide the best mechanism for us to be fully active in this sector and will provide the university with the greatest opportunity to be of service to health care providers and citizens of the state.

Thank you for the opportunity to testify. Our Associate Dean, Dr. J.S. Reinschmidt, and I are both available to provide further information regarding specifics of this testimony or other activities of the university in the rural health care sector.

SENATOR GENE TIMMS - TESTIMONY
CONGRESSIONAL HEARING ON RURAL HEALTH
August 18, 1988 Baker, Oregon

Since the 1987 legislative session, I have been very invovled in Rural Health. I have had the opportunity to attend numerous meetings on the subject. Rural Health Care is a very important issue in Oregon and throughout this nation. Although the problem is still acute in Oregon, this state is leading the nation in trying to solve rural health problems. The Federal Government, due to its policies, especially those regarding DRG's has made it harder for doctors and rural hospitals to survive. The Oregon legislature passed SB#428, which has been, and will continue helping rural hospitals and health care in Oregon.

The meeting we held in Baker had in attendance the 8 "At-Risk" hospitals in the state, and together we prioritized technical assistance to rural hospitals through SB# 428. In addition, we created more revenues with skilled nursing beds and waver of certification of need.

The way that we accomplished this was by tying Rural Health to Economic Development. Ellingson Lumber, John Day Lumber, and industry thoughout rural Oregon is dependent on health care for its existence.

Hospitals are one of the biggest employers in small communities. 6/10 of one job in the community is created by one hospital job.

Emergency medical service, along with the 911 number, are important in Oregon to save life and property. Costs to small business are dependent on these services.

In rural areas, the population of retired persons is growing, and these people are much better off financially. In ~~the~~ 1980, one in every nine persons was over 65, in the year 2030, one in every five will be over 65. 18 to 20 percent of the income in Baker County comes from retirement. These people are dependent on health services.

At this time, I would like to talk to you briefly about SB# 428. First of all, this bill set up a program in the Office of Rural Health that would provide technical assistance to hospitals defined as "Rural." Three types of hospitals fall under this definition:

1) Type A are hospitals that are small and remote, have fewer than 50 beds, and are greater than 30 miles away from another acute care facility.
2) Type B are hospitals that are small and remote, have fewer than 50 beds, and are less than 30 miles away from another acute, in-patient care facility.
3) Type C are hospitals that have more than 50 beds, but are not a referral center.

The technical assistance that these "Rural" hospitals are to receive as provided for by this bill fall into five categories. Oen of the most important is assistance that provides a link between rural hospitals and State and Federal policies concerning regulation and payment sources. Another is the recruitment and retention program for physicians and primary care providers, plus three other categories of technical assistance.

The final part of this legislation that makes it so important is that the "availability of health care services in underserved areas," was added to the Economic Development Policy of the State of Oregon.

Politically we can sell health care in this country because it is Economic Development -- Health care means "jobs."

SB# 428 would have never seen the light of day in the Human Resource Committee. I can't overemphasize the need to relate Health Care to Economic Development in both this state, and this nation.

In conclusion, I believe that we have taken long strides forward for Health Care in Oregon. This has been a bi-partisan effort. Both my Representatives, French and Jones, the Senate President Senator Thorne, and many others have made Health Care a priority issue in Oregon

I appreciate the opportunity to be here and believe that it is important, Congressman, that we meet in areas that are really facing Rural Health problems. Meetings such as this one will help solve those problems. Thank you.

64th OREGON LEGISLATIVE ASSEMBLY–1987 Regular Session

B-Engrossed
Senate Bill 428

Ordered by the Senate June 8
Including Senate Amendments dated May 8 and June 8

Sponsored by Senators TIMMS, BRENNEMAN, HANNON, KENNEMER, KINTIGH, SIMMONS, THORNE, Representatives FRENCH, D. E. JONES

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes policy on rural hospitals. Directs Office of Rural Health to provide services to rural hospitals. Requires full reimbursement to rural hospitals for medical assistance. Defines "rural hospital." Makes health care part of economic development policy. Increases licensing fees for hospitals and special inpatient care facilities. Directs Health Division to provide application forms to and collect biennial nonrefundable fee from all hospitals applying to be categorized or designated as trauma system hospitals. Specifies four levels of fee amounts.

Appropriates $316,842 from General Fund to Adult and Family Services Division for biennium for rural hospital reimbursement.

Limits biennial expenditures from federal funds collected or received by Adult and Family Services Division for rural hospital reimbursement to $396,056.

Declares emergency, effective July 1, 1987.

A BILL FOR AN ACT

Relating to hospitals; creating new provisions; amending ORS 184.003, 414.065, 441.020 and 442.470; appropriating money; limiting expenditures; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Legislative Assembly finds that Oregon rural hospitals are an integral part of the communities and geographic area where they are located. Their impact on the economic well being and health status of the citizens is vast. The problems faced by rural hospitals include a general decline in rural economies, the age of the rural populations, older physical plants, lack of physicians and other health care providers and a poor financial outlook. The Legislative Assembly recognizes that the loss of essential hospital services is imminent in many communities.

SECTION 2. Section 3 of this Act is added to and made a part of ORS 442.470 to 442.500.

SECTION 3. The Office of Rural Health shall institute a program to provide technical assistance to hospitals defined by the office as rural. The Office of Rural Health shall be primarily responsible for providing:

(1) A recruitment and retention program for physician and other primary care provider manpower in rural areas.

(2) An informational link between rural hospitals and state and federal policies regarding regulations and payment sources.

(3) A system for effectively networking rural hospitals and providers so that they may compete or negotiate with urban based health maintenance organizations.

(4) Assistance to rural hospitals in identifying strengths, weaknesses, opportunities and threats.

(5) In conjunction with the Oregon Association of Hospitals, a report which identifies models that will replace or restructure inefficient health services in rural areas.

NOTE: Matter in bold face in an amended section is new; matter *[italic and brackets]* is existing law to be omitted.

SECTION 4. ORS 414.065 is amended to read:

414.065. (1) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Adult and Family Services Division shall determine, subject to such revisions as it may make from time to time:

(a) The types and extent of medical and remedial care and services to be provided.

(b) Standards to be observed in the provision of medical and remedial care and services.

(c) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(d) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(e) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the division and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the division for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to paragraphs (a), (b) and (c) of subsection (1) of this section for the eligible medically needy may be less but shall not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for the categorically needy.

(5) Notwithstanding the provisions of this section, the division shall cause Type A hospitals, as defined in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed fully for the cost of covered services based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report, provided by the hospital to a person entitled to receive medical assistance.

SECTION 5. ORS 442.470 is amended to read:

442.470. As used in ORS 442.470 to 442.500:

[*(1) "Agency" means the State Health Planning and Development Agency.*]

[*(2)*] **(1)** "Council" means the Rural Health Coordinating Council.

[*(3)*] **(2)** "Office" means the Office of Rural Health.

[*(4)*] **(3)** "Primary care physician" means a doctor of family practice, general practice, internal medicine, pediatrics and obstetrics and gynecology.

[*(5) "Rural area" means any area designated as a rural area by the State Health Planning and Development Agency.*]

(4) "Rural hospital" means a hospital characterized by one of the following:

(a) Type A hospitals are small and remote and have fewer than 50 beds, and are greater

[than 30 miles to another acute inpatient care facility;

(b) Type B hospitals are small and rural and have fewer than 50 beds, and are less than 30 miles to another acute inpatient care facility; or

(c) Type C hospitals are considered rural and have more than 50 beds, but are not a referral center.]

SECTION 6. ORS 184.003 is amended to read:

184.003. (1) The Legislative Assembly recognizes that:

(a) There exists in the state a great and growing need for balanced economic and community development to provide and maintain orderly economic growth and the preservation and enhancement of all facets of Oregon's environment;

(b) Only properly planned and coordinated growth and development can maintain and improve the total environment which strengthens all of our communities in the marketplace, can meet the challenge of creating a positive economic climate and can insure the efficient provision of public and community facilities and services essential to development;

(c) An imbalance presently exists in the degree of economic health among Oregon communities and balanced development opportunities must be made available to bring about the geographical distribution of business and industry necessary to a healthy economy and environment for all Oregonians;

(d) Oregon cannot offer an attractive future to its citizens, unless new jobs are made available; and without new payrolls and the expansion of existing payrolls the state will suffer a loss of its families and young people, a decline of its communities and damage to our quality of life;

(e) Assistance and encouragement of balanced industrial, commercial and community development, **[including the availability of health care services in underserved areas,]** and of enhanced world trade opportunities are important functions of the state and that the welfare of the state, its people and its institutions depends upon a coordinated program to achieve this development and enhancement on an orderly basis;

(f) The availability of this assistance and encouragement is an important inducement to industrial and commercial enterprises to locate and expand in those portions of the state which will contribute most to the environment and economy of Oregon and that the full cooperation of state, local and federal agencies is necessary to this end; and

(g) Development of new and expanded overseas markets for world trade is an area of great potential for furthering economic growth and can be especially significant in the field of increased processing of Oregon agricultural commodities and manufactured products thereby contributing to economic diversification.

(2) It is the purpose of ORS 184.001 to 184.198 to:

(a) Assist in the maintenance and improvement of the existing economic base of the state;

(b) Diversify the economic base of the state;

(c) Expand international trade;

(d) Assist the economically lagging areas in the state; and

(e) Accomplish the purposes of this subsection in a way that complies with all local, state and federal regulations relating to environmental quality.

(3) In order to accomplish the purposes of ORS 184.001 to 184.198, the department may expend moneys duly budgeted to pay the travel and various other expenses of industrial or commercial site location agents, film or video production location agents, business journal writers, elected state of-

ficials or other state personnel whom the director determines may promote the purposes of this subsection.

SECTION 7. ORS 441.020 is amended to read:

441.020. (1) Licenses for health care facilities shall be obtained from the division.

(2) Applications shall be upon such forms and shall contain such information as the division may reasonably require, which may include affirmative evidence of ability to comply with such reasonable standards and rules as may lawfully be prescribed under ORS 441.055.

(3) Each application shall be accompanied by the license fee. If the license is denied, the fee shall be refunded to the applicant. If the license is issued, the fee shall be paid into the State Treasury to the credit of the division for carrying out the provisions of ORS 441.015 to 441.063 and 431.607 to 431.619. License fees paid for the first year following July 26, 1977, shall be prorated to reflect the change in license period provided in ORS 441.025 (2).

(4) Except as otherwise provided in subsection (5) of this section, for hospitals and special inpatient care facilities with:

(a) Less than 26 beds, the annual license fee shall be *[up to $180]* **$360 for 1988 and up to for subsequent years.**

(b) **Twenty-six beds or more and less than 50 beds, the annual license fee shall be** *[up to $230]* **$460 for 1988 and up to $690 for subsequent years.**

(c) Fifty or more beds and less than 100, the annual license fee shall be *[up to $400]* **$800 for 1988 and up to $1,200 for subsequent years.**

(d) One hundred beds or more and less than 200, the annual license fee shall be *[up to $520]* **$1,040 for 1988 and up to $1,560 for subsequent years.**

(e) Two hundred or more beds, the annual license fee shall be *[up to $640]* **$1,280 for 1988 and up to $1,920 for subsequent years.**

(5) For long term care facilities with:

(a) Less than 16 beds, the annual license fee shall be up to $120.

(b) Sixteen beds or more and less than 50 beds, the annual license fee shall be up to $175.

(c) Fifty beds or more and less than 100, the annual license fee shall be up to $350.

(d) One hundred beds or more and less than 200, the annual license fee shall be up to $450.

(e) Two hundred beds or more, the annual license fee shall be up to $580.

(6) During the time the licenses remain in force holders thereof are not required to pay inspection fees to any county, city or other municipality.

(7) Any health care facility license may be indorsed to permit operation at more than one location. In such case the applicable license fee shall be the sum of the license fees which would be applicable if at each location were separately licensed.

(8) Licenses for health maintenance organizations shall be obtained from the Insurance Commissioner pursuant to ORS 731.072.

SECTION 8. Section 9 of this Act is added to and made a part of ORS 431.607 to 431.619.

SECTION 9. (1) Applications to be categorized or designated as trauma system hospitals shall be made upon forms provided by the Health Division. Applications shall be accompanied by payment of costs incurred by the division to survey facilities for the purpose of assessing compliance with standards. The charges shall not exceed the actual costs of the surveys.

(2) The division shall collect a biennial nonrefundable fee from all hospitals which are categorized or designated as trauma system hospitals.

(3) The fee amounts shall be as follows:

Level I	$ 10,000
Level II	$ 6,000
Level III	$ 1,000
Level IV	$ 500

(4) Fees collected under subsection (3) of this section shall be deposited to the Health Division Account to be used only for the purpose of collecting and analyzing information related to prevention of trauma and monitoring of the trauma system. All such information shall be exempt from public disclosure except as statistical reports compiled by the division.

SECTION 10. In addition to and not in lieu of any other appropriation, there is appropriated to Adult and Family Services Division from the General Fund, for the biennium beginning July 1, 1987, the sum of $316,842 for rural hospital reimbursement under ORS 414.065 (5).

SECTION 11. Notwithstanding any other law, the maximum limit is established for the biennium beginning July 1, 1987, as the maximum limit for the payment of expenses from federal funds collected or received by the Adult and Family Services Division for rural hospital reimbursement under ORS 414.065 (5).

SECTION 12. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1987.

RURAL HEALTH CARE CRISIS
CONGRESSIONAL TESTIMONY GIVEN BY MICHAEL NELSON, AUGUST 18, 1988

Congressman Wyden, the people of Baker have worked hard to successfully initiate a local economic recovery. The Baker Industrial Development Commission, Baker Industrial Resource Commission, Baker County Chamber of Commerce, and the Baker County Court have all done an admirable job in effecting that recovery.

However, a major catastrophe is on the horizon that will nullify all of these efforts. The catastrophe is the possibility of losing our hospital and physicians. Without them, the cornerstone of economic stability, our communities will be an economic wasteland!

In making economic development proposals to companies who are considering locating in Baker, we have found that one of the first questions they ask is "Tell us about your hospital." A community without decent health care simply cannot attract new business. If something is not done to remedy the current situation, several rural hospitals in Oregon will be forced to close their doors, and those communities will be closing the door to new business.

I have presented you with comprehensive documentation assessing the sources of the rural health care crisis. The Baker County Medical Association feels that the number one problem is the difficulty in recruiting and retaining physicians in rural areas. Add to that an unfair medicare reimbursement program for rural vs. urban hospitals and physicians, inadequate medicaid reimbursement to physicians, and the generally poor economic health of rural Oregon, and we indeed have a funding crisis on our hands. The crisis is exacerbated by the higher percentage of medicare users in rural areas, and the subsequent drain on already insufficient medicare funds.

Doctors practice in Baker because they like it here. They don't want to be forced to leave. And we don't intend to let our economic recovery backslide. The documentation I have provided you with outlines some proposals we can act upon, and must act upon, to ensure our physical and economic health. Some of these include:

1. Instituting tax incentives for rural physicians.
2. Providing for continuing education for rural physicians through Area Health Education Centers.
3. Creating a Medicare reimbursement program which favors rural hospitals rather than discriminating against them.
4. Increase Oregon's Medicaid reimbursement for physicians.
5. Create an Eastern Oregon Office of Rural Health.

There are many more common sense solutions enumerated in this document. Congressman Wyden, all of our work and all of our solutions go in vain without dedicated and caring people like you. We need your help. Your history clearly exemplifies your concern for health care and the elderly. We ask you to help lead us towards implementing some of these solutions. Our communities are depending on it.

SUMMARY AND ANALYSIS OF PROSPECTIVE PAYMENT SYSTEM
AT
ST. ELIZABETH HOSPITAL AND HEALTH CARE CENTER
Baker, Oregon

HISTORY

St. Elizabeth Hospital was opened in Baker in 1897 and has continuously served the residents of this region since that time. It is sponsored by the Sisters of St. Francis of Philadelphia and is a member of the Franciscan Health System of Chadds Ford, Pennsylvania. We are licensed for 49 acute care beds and 80 long term care beds. We have an active outpatient service, including the second oldest Home Health Agency in Oregon, a Home Oxygen service, and a day surgery program.

St. Elizabeth Hospital is a sole community provider of acute health services, with the next nearest hospital located over 43 miles away. We employ nearly 220 employees or 180 full time equivalents with an annual payroll of over 3.2 million dollars (combined staff of hospital and health care center).

Our supply purchases from local and regional sources constitutes approximately 66.62% of our total supply budget, or $599,585.63.

Our emergency room is open 7 days a week, 24 hours a day, and is staffed by a licensed nurse and physician at all times. We see over 6,714 people annually in the Emergency Room.

The medical staff of 15 active staff physicians at St. Elizabeth's is well qualified and dedicated to the practice of quality medicine. Most could earn considerably higher salaries in urban areas, but have chosen to remain in Baker because of quality of life issues and a sincere concern for the wellbeing of the people of their community. The ability of the physicians to practice medicine in Baker is linked directly to the

continued existence of the hospital, and each is inter-dependent upon the other in order to provide medical care services to this community.

The patient payor mix at St. Elizabeth's is representative of the demographics of Eastern Oregon, with a higher than average percentage of Medicare patients (approximately 52% of our total revenue comes from Medicare). This is more than 10% higher than the Medicare average for rural hospitals nationally.

The current federal reimbursement strategy for Medicare healthcare reimbursement is rapidly leading to a crisis in the viability and quality of healthcare services in this country, particularly in hospitals serving a high percentage of elderly patients.

St. Elizabeth's has survived the first four years of DRGs only because of an extraordinary set of circumstances, including a very supportive national health care system (The Franciscan Health System); the generosity of a benefactor to all of Baker, Mr. Leo Adler; the support of civic groups such as the Soroptimists and Hospital Auxiliary; and the loyalty of the medical staff and hospital employees, who have chosen to stay with us in spite of more lucrative opportunities elsewhere, and the support and guidance of a sophisticated and dedicated Board of Trustees.

As an example of the impact of the DRG system on this hospital, the percentage of contractual allowance taken by Medicare (discount from charges) has risen steadily from 5.5% in 1981 to 16.1% in 1986.

Looked at another way, that is, on an actual cost basis, Medicare is reimbursing this hospital for inpatient services at 87.1% of our actual costs, which effectively means an average loss of 12.9% on services provided to our Medicare patients. It is virtually impossible for a small rural hospital to survive the present, much less plan for the future, when we lose money on more than 50% of the patients we serve.

In gross dollar figures, Medicare contractuals (discounts) have risen from $220,000, representing 5.5% of gross revenue in 1981 (a period when the hospital was on a cost-based reimbursement system), to over 1.1 million dollars, or 16.4% of gross revenue, in 1987. This figure alone represents

one-seventh of our total revenue budget.

The economic impact of the prospective payment, or DRG System, is not immediately apparent to the outside observer. Patients still receive appropriate care and on the surface it appears as if hospitals are doing business as usual. What is generally missed, however, is the severe damage being done to the future viability of hospitals due to their inability to fund depreciation adequately or to acquire necessary technological equipment.

While the prospective payment system cannot be held fully accountable for the financial difficulties which we have experienced at St. Elizabeth's since the DRGs went into effect, it certainly represents a significant part of the problem. I believe the same can be said for rural hospitals across the nation.

Other factors which have also affected the financial stability of this and other hospitals include the condition of the local economy, declining utilization rates nationally, increasing use of outpatient services (which are generally staff-intensive in terms of providing care, but which produce less revenue than inpatient services), and a growing amount of uncompensated care (339,000-1986; 348,000-1987; 464,000-1988).

Many of the trends we are all experiencing in the delivery of health care services are good ones and are reflective of healthier life styles and improved medical knowledge and technology. Shorter lengths of stay, increasing use of outpatient services, and the growth of home care services, all contribute to more efficient and convenient services to the public and at lower costs than would have been possible (on an adjusted dollar basis) even five years ago.

In order for hospitals to survive these healthy trends, however, the Health Care Financing Administration (HCFA) needs to reimburse hospitals on a more equitable basis than the prospective (DRG) methodology, which was not originally designed as a reimbursement methodology, but rather as a quality measurement system which was later modified by HCFA to serve

as a reimbursement tool. It is an extreme example of a pound-to-fit, paint-to-match philosophy.

While recognizing the need to control healthcare expenditures on a national level, it seems that these savings could and should be achieved through other means than refusing to pay a fair share for services rendered.

Whether intended or not, the present DRG system will eventually produce a rationing of healthcare services for the elderly. In other words, HCFA is stating through this system that it will only pay "X" number of dollars for the care and treatment of a person over 65 years of age, by diagnosis, regardless of how much it actually costs to treat the patient. At some point soon, hospitals will have to begin a painful assessment of which services they must discontinue just to survive. If unprofitable services are discontinued, it will become increasingly difficult for Medicare patients to access care for treatment for these "unprofitable" diagnoses and in fact they will be forced to wait for treatment until space is available at the few remaining hospitals which can afford to provide the service.

Such a scenario will not be the result of hospital disinterest in the needs of the elderly patients; it will be rather the direct result of HCFA reimbursement policies which have forced many hospitals to the brink of financial disaster.

What can be done to help avoid this impending crisis in healthcare? Some suggestions are:

1. Eliminate wage differentials between urban and rural hospitals.
2. Reimburse physicians at a fair rate for services rendered to Medicare patients.
3. Recognize real increases in the cost of doing business for hospitals and physicians (for example, increases in food prices, supply costs, utility rates, malpractice rates, wage rates, etc.) as originally promised by Congress (market basket adjustments).
4. Eliminate DRGs as a reimbursement tool and replace it with one which is both reflective of actual services rendered and related to national quality standards.

Some response has already occurred to correct the financial distress caused to rural hospitals in this State. Since October of 1987, as a result of Senate Bill 428, introduced by Senator Gene Timms and supported by Representative Ray French, among others, Oregon has been reimbursing eight at-risk rural hospitals on a cost-based system, instead of the previous system of Medicaid DRG rates. As an example of the difference this can make to a rural hospital, I will briefly describe a case brought to our emergency room last fall. The patient arrived unconscious, in acute respiratory failure. Resuscitation efforts in the Emergency Room were successful, and the patient then underwent emergency surgery, again successfully, was transferred to the intensive care unit and, after stabilization, was transferred for several weeks to medical floor. The patient was thereafter transferred to a rehabilitative unit in another city. The DRG Medicaid payment for these services would have been approximately $3,620. The payment under cost-based reimbursement was $28,230, a difference of almost $24,610.

We have experienced many similar reimbursement discrepancies under Medicare DRG payment methodology, but in each of these cases we of course received the lower amount. Several losses of $20-30,000 in a single year can destroy a rural hospital bottom line. We simply do not have the volume to make up the difference on other cases which are marginally profitable.

Nor is St. Elizabeth's standing idly by, waiting for a lifeline to be thrown by the federal government. We continue to seek new ways to reduce costs without affecting the quality of our services, and in fact we are currently engaged in a major consolidation effort with St. Anthony's of Pendleton, a sister hospital, to help achieve further reduction in operational overhead expenses through the sharing of personnel and services in non-clinical areas. But regardless of our efforts, unless the reimbursement system of the Medicare Program begins to pay at least the actual cost for services rendered, this hospital and others like us throughout the United States, will be damaged beyond hope of recovery. The medical and financial ramifications of such an event would be catastrophic to the heartland of America.

I urge your support of our hospital, and others like us, to redress the inequities of the prospective payment system. Thank you, Mr. Wyden, for

your interest in the problems of rural healthcare, and for taking the time to visit Baker to obtain information directly.

Submitted by: Walter S. Busch
Administrator

St. Elizabeth Hospital and Health Care Center
P. O. Box 766
Baker, Oregon 97814
(503) 523-6461

Craig P. Hooton, Consultant
Eastern Oregon State College
LaGrande, Oregon 97850

STATEMENT OF DON EVERSON, FIRE CHIEF, BAKER, OR

The Baker Fire Department provides basic life support ambulance service to the City of Baker and also to a large part of Baker County, part of Grant County in the Granite and Austin Junction area, and part of Union County in the North Powder, Medical Springs, and Pondosa area.

The ambulance service as an integral part of the Baker Fire Department,is funded out of the General Fund of the City of Baker, with no support from Baker, Union, or Grant County.

The user fees for ambulance service to non residents of the City of Baker are increased to help defray some of the expense of providing ambulance service to those areas.

Base Rate for Residents:
$100.00 + $2.00 per patient mile

Base Rate for Non-Residents:
$300.00 + $3.00 per patient mile

In 1987 218 calls out of a total of 595 were for service outside the city. Time in service was 392 hours for outside city calls out of a total of 601 hours. Miles travelled in service was 12,703 for outside calls out of a total of 15,228.

The Baker Fire Department has 12 full time paid firefighter EMTs who are trained to the EMT I level.

While any increase in the level of training for fire department personnel would be beneficial to all patients, the biggest impact would be on the long runs out of the city, where the only care possible for sometimes several hours is the EMT on the ambulance.

The City of Baker is faced with three major problems:

1) The expense of providing ambulance service into the rural areas.

2) The expense of maintaining and increasing the level of training.

3) Difficulty in finding available classes and instructors for Level II training and above.

Applied Humanomics

August 11, 1988

Erin L. Forell, District Assistant
c/o The Honorable Ron Wyden
United States House of Representatives
500 N.E. Multnomah, Suite 250
Portland, OR 97232

Dear Erin:

Attached with this letter please find my testimony for the Rural Health Care Hearing in Baker. I will plan on arriving at the Baker County Courthouse prior to 9 a.m. I am planning on leaving Baker around noon. Please advise me if you think it advisable to allocate any more time for this.

In addition to my volunteer capacity with the Southeast Oregon Rural Health Network, I am President of Applied Humanomics on whose letterhead this is printed. Applied Humanomics is a company which provides electronic messaging services, allowing our customers to exchange information with each other using their computer and modem. We have over 750 customers in over 20 countries.

Many of my remarks on AIDS were culled from an electronic mail conference Applied Humanomics is currently sponsoring over Telemail to educate our users and exchange information regarding AIDS. It appears that the Telenet corporation will print and disseminate the proceedings from this conference which concludes at the end of September. I make these points to show how some businesses and individuals are assuming active roles and fulfilling civic responsibilities as this public health epidemic unfolds.

As you can no doubt tell from reading my testimony, the issues of health care and AIDS are very personal concerns of mine. I appreciate the opportunity you have afforded me of presenting testimony on these issues. Please be assured I will do everything in my capacity to assist you and Congressman Wyden with respect to these issues.

Sincerely,

Mike Herron

MH/ss
Enclosures

P.O. Box 1239
Klamath Falls, Oregon 97601-0067
Telephone (503) 884-3383

Applied Humanomics

August 10, 1988

The Honorable Ron Wyden
United States House of Representatives
B-363 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Wyden:

Thank you for the opportunity of presenting testimony on the issue of Rural Health Care. I shall endeavor to keep my remarks brief and to the point.

My name is Mike Herron and I am President of the Board of Directors of the Southeast Oregon Rural Health Network (SORHN) in Chiloquin, Oregon. SORHN is a consortium of isolated rural communities which have banded together in an effort to ensure that residents have access to adequate health care services. The mission of SORHN is to ensure that health care and related services are provided to unserved and underserved populations in Southeastern Oregon.

Background on Southeast Oregon Rural Health Network

The SORHN service area covers some 25,000 square miles of Southeastern Oregon. SORHN provides the only access to primary health care for a widespread population of approximately 15,000 people. The three community health clinics operated by SORHN (Chiloquin Medical Center in Chiloquin, Sprague Valley Medical Center in Bly, and North Lake County Health Center in Christmas Valley) serve class one health manpower shortage areas (HMSA) as designated under the Public Health Services Act. A vast majority of our patients are the medically indigent, Medicare or Medicaid eligible, and Native American. Statistically, we find that some 26% of our patient population are illiterate, and/or economically disadvantaged, as well as geopolitically isolated.

Chiloquin Medical Center (CMC) is staffed with physicians. Sprague Valley Medical Center (SVMC) and North Lake County Health Center (NLCHC) are staffed with Physician Assistants. Throughout the network we provide basic medical care to the residents in the respective geographical areas. More extensive medical care is provided by referring patients either to Klamath Falls, Medford, Bend or Lakeview for follow-up by physician specialist or hospitalization. Depending on the referral need, the patient may be required to travel from 52 to 210 miles round trip, sometimes more, to receive appropriate health care.

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As with many rural areas, our population and needs are diverse. We have many senior citizens trying to survive on fixed incomes while living costs escalate dramatically. They have all the special health concerns that accompany old age. We have a significant number of Native Americans, comprising one quarter of the total population. Special attention must be paid to their culture and values in addressing their health care needs. A large number of service area residents are employed in farming or timber, two of the industries that have been plagued by problems and instabilities. Distance and inclement weather present yet another set of obstacles. The needs of the rural segment of our population are clear. What is not clear is our nation's commitment to meeting these needs.

I would like to focus my remarks on two areas of increasing concern to SORHN: (1) what must be done to ensure the availability of health care services in rural communities; and, (2) the AIDS public health epidemic and the impending impact of this disease in rural areas.

Ensuring the availability of health care services in rural communities

Fact: At the SORHN Board of Directors meeting on July 27, 1988, a motion was unanimously approved to temporarily close the North Lake County Health Center effective August 16, 1988 until the following conditions are met:

- A full time health care provider (Physician Assistant or Nurse Practitioner) can be recruited and certified by the state of Oregon.

- A physician preceptor can be located in the La Pine/Bend area to ensure quality of care and patient continuity concerns are better addressed.

- Supplementary funding can be located to cover the expected operating losses until the clinic can build its client flow and operate on a self-sufficient basis.

Comments: The decision to temporarily close the North Lake County Health Center did not come easy for the SORHN Board of Directors at that meeting. The Board realizes that this means that residents of North Lake County are once again without any primary health care services within a hundred miles. However the Board had to balance the issues of fiscal responsibility (i.e., we cannot operate at a loss without any means of covering the losses), quality of care (the difficulties involved in adequately providing supervision from 100 miles away as well as quality and continuity of care for patients), and our commitment to providing health care for the residents of the communities participating in our consortium.

Problem: We are currently unable to locate a mid-level health care provider who is willing to work full-time and live in the community involved. Despite extensive advertising, networking with other health care organizations, and other recruitment efforts, SORHN has been unable to locate a qualified applicant.

Solution: Re-establish the National Health Service Corps (or a similar entity) and have a major focus on training mid-level providers in addition to physicians. Offer scholarships which can be worked off through service provision in class one health manpower shortage areas (HMSA).

Problem: Even if we were able to locate a qualified applicant and negotiate an acceptable compensation package, the certification process and preceptorship requirements make it virtually impossible to adequately supervise providers in remote locations, accomplish the certification and other paperwork processes in less than six months, and insure quality of care issues are satisfactorily addressed.

Solution: When legislation is drafted nationally, statewide or locally, make sure that practitioners are consulted (as in these hearings) and that their input is taken into account. Even more important, once the legislation is passed and the procedures and regulations are being written, involve practitioners actively in the formulation of the rules by which they will have to abide. They know what the problems are at the service delivery level and what must be done to solve them. All too often the regulations systematically prohibit the service providers from accomplishing the intent of the legislation. Get practitioner input and revise current regulations to remove unnecessary barriers to operation.

Problem: Rural health clinics, like any other startup enterprise, will experience operating losses until the clientele is established and services are in full operation. This is a particularly acute problem for non-profit organizations with no capital resources to defray losses. Services must be available on a full-time basis to assure full utilization by the community.

Solution: Provide some form of subsidy or incentives during startup periods to defray anticipated losses until the clinics are operating profitably. Outright gifts are somewhat counterproductive in that they promote the concept that the clinic is subsidized and that services are "free" and do not have to be paid for by clinic users. Rather it should take the form of an interest free loan which can be repaid at a later date either in cash from revenues or repaid (similar to NHSC scholarships) by maintaining services for a specified period of time in the service area.

Problem: Individual clinics cannot afford necessary overhead costs to keep fee for services at competitive levels and maintain professional management capability. Clinics must be able to operate effectively and efficiently, be financially responsible, be effectively administered, use cost saving techniques and procedures, etc.

Solution: Enact legislation and funding which promotes and encourages the concept of consortium building to spread management costs among a number of service delivery entities. Hold such consortiums accountable and responsible without throttling them so they cannot operate. Determine which models work and disseminate the findings together with technical assistance to other communities interested in developing similar consortiums.

AIDS and rural health care

Fact: Public health experts predict that by 1991 every man, woman and child in the United States will personally know someone who has either died of AIDS or is currently infected with the disease. Although there is yet no known cure for AIDS, the spread of the disease can be prevented. Further, the quality of care and services for those who have contracted the disease can be substantially improved. Persons who will be infected with AIDS in the future will come from all segments of our society, not just high-risk populations such as gays and intravenous drug users.

Comments: Many of us have heard the story of Ryan White, the sixteen year old hemophiliac who has been fighting a struggle with AIDS for several years. That's one of the cases which has received national attention. Not all cases receive such notoriety.

On Sunday, July 24th, 1988, a 12 year old boy named Nathan Henderson died of AIDS. His father, Dan, is a good friend of mine. Nathan had been diagnosed with leukemia at age five in 1981. He underwent two years of chemotherapy and the leukemia was pronounced in complete remission. Unfortunately a part of his therapy included transfusions and in 1986 Nathan was diagnosed with AIDS. He got it from receiving contaminated blood during the transfusions. Nathan's memorial service was held on July 28th.

The tragedy didn't end with Nathan contracting the disease. His uncle, terrified of the virus, forbid Nathan any contact with his family. Nathan never saw his two favorite cousins again. Nathan and his half-brother and half-sister all attended the same private school. The owner, afraid of parents who would pull their children out when they learned that Nathan had AIDS, even though Nathan himself could no longer attend school because of his physical condition, threatened to throw out his half-brother and half-sister. A concerted education effort by Nathan's doctors finally prevented that, but it wasn't easy. Nathan's dying process was unnecessarily lonely, isolated from many members of what should have been his support system. Although their presence could not have cured Nathan, they could have made his final days, months and years much happier and more positive. Ironically, because of the very nature of AIDS, Nathan was much more at risk of acquiring a fatal infection from others than they were at risk of acquiring AIDS from him.

I personally notified Dan of the qualified successes of the drug AZT in the treatment of AIDS in the spring of 1986. Dan discussed this with Nathan's doctors that very same day and an application to use AZT in Nathan's treatment was submitted. Nathan was not allowed to receive the medication until October of 1987. Between the onset of the treatment with AZT and his death, Nathan was able to experience some quality time when he appeared and felt like a "normal" child. Why was this delay in treatment necessary at all?

From a lady named Marilyn in Massachusetts, an 11 year cancer survivor, comes a similar tale. "I received 144 units of Factor VIII and blood transfusions in August 1984, for

my last of six operations; an experimental antihistamine blocked platelet clotting factors and a month could not be waited for the drug to get out of my body. Massachusetts General Hospital refused to test me for AIDS for 2 1/2 years until the Center for Disease Control (CDC) recommended all transfusion patients before 1985 get tested. The AIDS hotline in Boston told me there was nothing to worry about. Why were all these people in denial? I read where there were only 10 AIDS deaths in China and all had received American Factor VIII. The Post article told me why there was denial - the refusal by blood banks and gay rights people to safeguard the blood supply when it would have protected patients like me. The $100,000 it would have cost to screen the blood supply will cost millions to provide health care to those it exposed the disease to. What do we do?"

The Center for Disease Control discovered the connection between AIDS transmission and transfusions from a hemophiliac child, diagnosed with AIDS, in January of 1983. Despite conferences and other efforts by CDC, mandatory blood testing did not begin until late in 1985 for a variety of reasons. Would someone else please be willing to try and explain why that happened to Dan and his family, to Marilyn, or to the families of the thousands of others who died of AIDS during that period?

A colleague, who operates community based programs for youth and families in North Dakota summarizes some comments concerning AIDS as follows:

"What does all this mean for rural health care? Traditionally rural communities do not have the necessary facilities, equipment or personnel to provide adequate health care. When we apply this situation to AIDS the problems are even worse because of the nature of the disease. The testing issue has recently surfaced here in North Dakota because of our 'ruralness'. We are currently working with a client who needs to be tested and both the client and family members are afraid to go in for the test because of the confidentiality issue. Everyone knows the test is supposed to be confidential, however everyone in a small town always knows everything about everyone else who lives there! Because of the lack of medical facilities, equipment and personnel in rural areas AIDS patients are forced to travel long distances to seek treatment, and as their condition worsens and they become less ambulatory they need home health care or services which are more accessible."

"Most gay young men leave North Dakota so they can lead a more open life style in other places. However, when they are diagnosed with AIDS many of them are returning home to their families. North Dakota has had several incidences of this. These young men are literally coming home to die. So in spite of the fact our AIDS incidence is really low in terms of the numbers of people who are contracting the disease in North Dakota, the numbers of actual AIDS patients needing treatment is growing in the rural areas. We are definitely not prepared to meet the medical needs of these patients."

The same person addressed the issue of AIDS and Native American populations by stating, "The Native American population has had an incredibly dramatic increase in cases on a national basis. During one four month period, the number of active AIDS

cases among Native Americans doubled from 26 to 53. It is difficult to track the exact number of Native American AIDS cases because they are in the CDC's 'other' category and are not listed separately. In North Dakota, Native Americans have the highest rate of sexually transmitted diseases. They have the highest rate of unemployment and poverty in our state. They also have the poorest overall health care and the highest addiction rates to drugs and alcohol. The Health Department considers them extremely high risk and wants to take preventive action quick!"

Problem: Preventing the spread of AIDS.

Solution: Making the education of the public and organizations working with the public, one of our highest national priorities. Educate people about:

- how AIDS is contracted and passed on
- prevention measures to prevent the spread of the disease
- acknowledgement that all segments of society are at potential risk of AIDS

We should encourage parent-child and peer conversations about sex which include information about preventing sexually transmitted diseases. We must educate people about the consequences of shared needles whether it relates to IV drug use, tatooing or ear piercing. We must identify programs which have worked to educate people and disseminate the model. We must allocate the resources necessary to carry out the education program throughout all segments of our society.

Problem: Improving the quality of life for those who have contracted AIDS.

Solution: in addition to making health care services available, we must again educate the public about:

- the myths surrounding AIDS
- who is at risk of contracting the disease
- how the disease is actually transmitted

We must overcome the mass hysteria surrounding the AIDS issue. We must educate everyone if those afflicted with AIDS are to be able to die with dignity, receiving compassionate care and support from their families, friends, health care providers and other support systems.

Problem: Finding a cure for AIDS.

Solution: We must allocate all possible resources, both financial and otherwise, to this end. We must work cooperatively with scientists and researchers throughout the world without regard to cultural or national barriers. We must put all possible solutions for curing AIDS, alleviating the discomfort of those afflicted with AIDS, or preventing further spread of AIDS into practice without undue delays and obstacles.

Conclusions

Regarding rural health care issues:

If one of the objectives of this country is to ensure equal access to quality health care services for all of our citizens than what we must do is clear. We must remove the barriers that exist for the provision of services in rural areas, we must direct our educational institutions to train the necessary health care providers, we must determine efficient and cost-effective service delivery models that work for diverse rural populations, we must disseminate these findings where needed, and we must provide the resources to make the transition to a self-sustaining capacity. We constantly hear that it is rural and middle American that make this country great. Let's prove that we mean what we say.

Regarding AIDS:

To sit idly by while countless numbers of our citizens die, to allow misinformation to make the dying and grieving process even more painful for those involved, to allow a disease to spread when we have the means to prevent it is a flagrant travesty of the values we so adamantly espouse to others. While we struggle to find a cure for AIDS we must educate everyone about the disease and how it is transmitted. We must remove the artificial stereotypes that have been created about those who have AIDS and treat them with the dignity and respect they deserve as fellow human beings. We must use all the resources we have to stop the spread of the disease. We have the communications tools and the knowledge necessary to accomplish this. To do less is to deny the value of the individual, the cornerstone upon which this country was founded.

Sincerely,

Mike Herron

MH/ss

MID-COLUMBIA MEDICAL CENTER
THE DALLES OREGON

August 18. 1988

TESTIMONY FOR RON WYDEN'S RURAL HEALTH CARE HEARING

I am Patricia Gardner, RN, Director of Visiting Health Services, a home health agency based at the Mid Columbia Medical Center in The Dalles, Oregon. We saw our first patient in May of 1978. Initially, we served Wasco County as far south as Maupin and Sherman County as far east to a ten-mile radius of Rufus and south to a ten-mile radius of Grass Valley. In January of 1979 we enlarged our geographic area to include Hood River County as far south as a ten-mile radius of Parkdale and west along the Columbia River to Cascade Locks. We also are licensed in the State of Washington to service a Southwest Washington area. We opened a branch office in Hood River in March of 1984.

Originally one registered nurse, a physical therapist and secretary, who ran the office, ~~and~~ made 1127 visits in our first year. In 1981, medical social services and speech therapy were added; home health aides were trained and added along with an occupational therapist in 1984. In our last fiscal year, ending July 1, 1988, we made 4051 visits and traveled 76,696 miles. Our labor statistics show that we require 3.36 hours per visit which includes administration time, direct patient care, travel, paper work as well as education. As indicated, the average miles per visit is 18.9. There is no extra charge to the patient for time spent traveling. The per visit charge that Medicare allows is averaged with all disciplines; nursing, physical therapy, home health aide, speech therapy and occupational therapy and amounts to $68.55. The average travel time per visit runs at least 30 minutes per patient. The employee is then in the home for one hour per patient and an average of an additional hour is spent on paperwork related to the visit. This translates into direct costs per visit of $40.00, leaving just $28.00 of the Medicare allowable amount to cover secretarial time, all other overhead costs, and any contribution to the hospitals bottom line. With acute care becoming a reality in the home setting our agency has found it necessary to staff on call nurses 24 hour per day, seven days per week. There is call time for 2 shifts, five days a week and 3 shifts two days. By the time staff benefits, overtime, weekend differential is added, there is little left for lights pagers, office space, etc. As you can tell, the current figure is is inadequate.

19TH AND NEVADA STREETS
THE DALLES, OREGON 97058
PHONE: 503-296-1111

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Some of the clients we have include:

I. A gentleman with a fractured leg that lives in Grass Valley, 100 miles round trip. This required 7 physical therapy visits. He also had a clot and fluid on the brain which required 5 nursing visits totaling $822.60 in Home Health charges over a period of one month as opposed to $1,927.50 for a nursing home stay for the same period of time.

II. A lady living in Maupin, 84 miles round trip, with skin ulcers that required wound care. Over one month, 5 nursing visits or $342.75 was charged as opposed to one month in a nursing home $1,927.50.

III. A lady terminally ill with leukopenia that, with our help, was allowed to be with her family when she died. This was a 16 miles round trip and required 10 nursing visits from May 13 through July 9 for a cost of $685.50 as opposed to 1 3/4 months in a nursing home for $3,373.12.

IV. A lady living in Tygh Valley, 60 miles round trip, suffered from Myosarcoma which resulted in above the knee amputation. She required nursing and physical therapy over a four month period to a total of 19 visits at a cost of $1,302.45 as opposed to a four month nursing home stay at a cost of $7,710.00.

V. A gentleman residing in Wasco, 64 miles round trip, who suffered from congestive heart failure that resulted in an enlarged heart, required both physical therapy and nursing visits totaling 13 visits over a 7 week period at a cost of $891.15 as opposed to nursing home placement of $3,373.12.

As you can see, there is a considerable savings in Home Health.

bt

Enclosure: map

OFFICIAL HIGHWAY MAP OF
OREGON
1982
Compiled and Published by
Oregon Department of Transportation
State Highway Division
Salem, Oregon
97310
SCALE
Stevenson
Carson
White Salmon
The Dalles
Goldendale
Wasco
Condon
Fossil
Richland
Pasco
Kennewick
Pendleton
SHERMAN
GILLIAM
MORROW
UMATILLA
WASCO
WHEELER
GRANT
CROOK
JEFFERSON
DESCHUTES
WARM SPRINGS
INDIAN

August 10, 1988

TO: United States House of Representatives
Committee on Small Business
Subcommittee on Regulation & Business Opportunities

FROM: Dennis M. Bruneau, PA-C
Gilliam County Medical Center
Condon, OR 97823

Chairman Wyden and Members:

Thank you for today's invitation to testigy before this committee in regards to the problem of access to primary health care services in remote and rural areas.

As a Physician Assistant I have been directly involved in the delivery of rural health services for the past 18 years. I have worked as a provider, administrator and as an educator in a primary care university based PA program.

For the past 8 years my partner, David Jones, PA-C, and I have represented 100% of the medical community in Gilliam County, Oregon.

Based in Condon, OR we provide 24-hour full-service primary health care with the exception of pre-natal and obstetrical delivery. The reason why we do not provide these services is because of the high cost of malpractice premiums required to cover us for liability.

Besides our duties at the clinic we are both involved at the State level which deals with administration and planning of health services and the regulation of physician assistants. Mr. Jones is chairman of the State Rural Health Coordinating Council and I am a member of the Physician Assistant Committee to the Oregon Board of Medical Examiners.

The problem of access to primary health care services in remote and rural areas has been well documented. I've provided an outline of problems and solutions which I feel are specific to my experience in the field.

The most over-riding factor, of course, is economics. The lack of adequate funding is forcing many doctors and other practitioners to leave the rural areas for a more limited service, urban based practice. In Oregon, the rural communities are experiencing a reduction of provider manpower. This is principally due to inadequate reimbursement, increase of malpractice premiums and other overhead costs while the rural economy has remained static and in many cases it's contracting.

The average per capita health bill is $1,900. But for people over 65 nearly $6,000 is spent. It is well documented that rural areas have a much larger percentage rate of senior citizens than urban locations.

The Reimbursement Problem

Medicare reimbursement under the Rural Health Clinic Act is in my view, an unfair reimbursement program for rural clinics.

Rural communities wishing to staff their clinics with PAs are burdened with stringent requirements to meet certification compared to physicians staffed in rural or urban clnics. For example, rural clinics under the Act must meet numerous criteria without any prospective technical/administrative assistance from the Federal regional office. It is a blind attempt while no deficiencies are allowed which may or may not be applicable to small rural health clinics. Additionally, once a clinic is certified federal regulation requires maintaining compliance and be insepcted annually by state agencies to determine compliance. For reasons I'm not aware, this annual review and recertification of rural clinics has not taken place in Oregon. The result has been rural clinics loosing motivation to stay in compliance by poor monitoring of the program.

The Medicare requirements imposed on rural clinics adds cost to their limited budgets and poor monitoring only breaks down any justification to the whole purpose intended.

Along with the administrative difficulties, the reimbursement allowance is inadequate. Certified rural clinics receive a fixed rate for services rendered. By contrast, physician staffed clinics are reimbursed for actual services. As stated previously, senior citizens tend to live in rural areas more than the young and they have more medical problems which increases the cost.

I have become aware that a new reimbursement system for rural clinics will be inacted in early 1989. I understand it will pay 85% of the physician's customary fees. If I'm correct, this allowance, I feel, is not sufficient while PAs working in rural health clinics must maintain periodic physician supervision and on-going consultation. This quality assurance relationship adds cost and I feel 100% reimbursement is a more fair value.

Health Service Districts

The Condon, Oregon experience is a rare example of success for rural health.

Federal funding programs, since the 1960's, have been available in a variety of forms to deal with problems of access to medical service for the medically under-served. The NHSC most recently has pulled back from their points of maximal impact in terms of numbers of

obligated physicians and mid-level practitioners in the field. This change has led to a need for greater contribution by state and local entities in the face of federal retrenchment.

The HSD was one mechanism for solving Condon's health care needs. In 1980 residents of Condon formed a special taxing district and levied a tax to subsidize a clinic which amounted to 50% of its anticipated budget. The remainder was to come from patient fees. Over the years the clninc has continued to operate with a modest profit margin. This is largely due to the maintenance of efficient services and a high collection rate. Currently, the subsidy has been reduced to about 32%, after calculating total income and expenses.

Other mitigating factors contributed to the success of the Condon clinic; the clinic is staffed by 2 PAs. The availability of 2 providers alleviated the problem of provider burn-out and isolation which is common to solo providers in rural areas.

The HSD, I believe, is one solution to the problem of financing health care services in medically under-served areas. There are roughly 28,000 special districts in the U.S. Only two are health service districts, Stickney, IL and Condon, OR. A third is under development in Ajo, AZ.

I feel communities like Condon wishing to assume responsibility for their own care by self-taxation should be granted start-up technical and financial assistance from federal and state levels to achieve their goal.

One might argue that funding from general tax dollars for local tax-based programs is unfair to others. I think it is more useful that local programs receive initial moneys and not rely on long-term federal support when the local means exists and community control is desired.

Making HSD legislation more widely known, developing more districts to serve as models, finding funds to pay for start-up costs and technical assistance, and enacting adequate allowable rates of local taxations will be essential if the HSD concept is to fulfill its great potential for financing primary care for the under-served. In an era of shrinking federal participation in health care for the medically under-served areas, the HSD is a viable concept that warrants serious consideration.

I. "The Rural Health Problem"

A. The causes

1. Economics

a. Limited industry

b. Fixed incomes, rural has 13.5% at or below poverty level

c. Low census

d. No coverage, 1 in 6 are without insurance coverage

e. Fixed Medicare payments

2. Professional isolation

a. No peer review

b. No consultation

3. Social isolation

a. Family

b. Personal

4. Burn-out

a. Always "on"

b. Many disciplines

5. Consumer expectations

a. "We want a doctor"

b. Hospital

c. Technology

6. Professional liability

a. Malpractice premiums from 1983-85 doubled from 1.7 billion to 3.4 billion

b. Ten-fold increase in claims filed last 5 years

c. Average amount of awards by jury verdicts rose 500% last 5 years

7. Rural clinics

   a. Most communities without care have no clinic or facility for one

   b. No equipment or dollars to buy them

8. Community resources

   a. Most small communities do not have resources or know how to set-up a rural health service

      (1) Grant writing-funding

      (2) Recruitment - PAs viable alternative

      (3) What services are needed and what can be achieved

II. Some answers to the "Rural Health Problem"

A. More equitable medicare reimbursement for rural health clinics

   1. Should be 100% of other providers receiving medicare reimbursment

   2. "Doing more for less" rationale for standards on medicare certification should be same for all clinics. Rural clinics must meet more criteria and receive less money for services.

B. Financing by Health Service Districts (HSD)

   1. Albiet rare, there are 2 successful HSDs in the U.S. and a 3rd under development

   2. The Stickney, Illinios model

   3. The Condon experience

   4. There are over 28,000 special districts in the U.S. as of 1982. Promotion of this concept should have serious consideration

      a. More widely known

      b. Developing more districts

      c. Funding start-up costs and technical assistance

      d. Enacting adequate allowable rates of taxation

C. Consortium concept

1. Sharing of manpower and/or services can enhance primary care delivery beyond the areas served by HSDs

   a. The Condon - Fossil connection

D. State laws

1. Medical practice acts should be adopted to promote mid-level providers access to provide primary rural health care

   a. Oregon's Physician Assistant law

   b. 12 medically underserved areas (MUAs) are served by PAs in Oregon

E. Continued funding of PA programs

1. Fund programs that intend to train PAs for rural health delivery and administrative duties

2. PAs are more likely to have higher level of job satisfaction in rural communities than MDs

3. PAs can provide reasonable and adequate care in rural areas at a salary cost less than an MD

4. Cost to train PAs is much less than to train MDs if they are to perform comparable duties in MUAs (average debt to MD before graduation is $40,000) (PA less than $10,000)

RECEIVED
AUG 8 1988
Hon. Ron Wyden

TESTIMONY: RURAL HOSPITALS' NURSING SHORTAGE

During the past year there have been many changes across our State in the area of healthcare. As a Director of Nursing in a rural hospital I have become concerned about the problems which are facing rural hospitals throughout the State of Oregon.

Rural hospitals in our State play a vital role in the health status, access to health services, and economic well-being of the citizens of the communities within which they serve.

Today rural hospitals are experiencing a wide scope of problems relating to lack of physicians, lack of capital, lack of diverse services and planning, declining inpatient use, and old existing facilities all of which has forced some to close their doors.

But it is also important that we identify national trends which are impacting healthcare; one of the most critical problems facing hospitals today is the nursing shortage. The rural hospital today faces an ultimate challenge in the education, retention and recruitment of one of its most valuable resources -- the nurse.

Traditionally, nursing has been viewed as an occupation requiring people who care, and that is still true today. But with the daily advances in medical science, the nurse's job has become increasingly complex and demanding. Nursing today still requires a caring heart, but it also requires a professional with a thorough understanding of the lastest advances in healthcare.

The scope of practice for a registered nurse in a rural setting covers medical, surgical, maternity, intensive and/or cardiac care, and emergency room. A colleague in a larger hospital may be assigned to only one of these units and thus becomes specialized within the nursing profession. Because nurses are licensed and are responsible for human lives, you can understand the immense responsibility that a rural nurse must face in the rural hospital.

It becomes a grave responsibility of the hospital to help the nurses in their facility to stay abreast of the current trends in order to be able to practice in their profession. Today most rural hospitals have limited amount of dollars allocated for inservice training and seminars. Because of the facility being isolated, it usually is difficult for the professional nurse to access programs without incurring expenses for mileage and lodging, besides tuition.

Another concern is the limited resources available to interested persons who wish to further their careers in nursing. In order to take classes at a college level, once again traveling becomes a deterrent usually due to the time it takes to go and return home.

Retention of the professional nurse has become another area of concern. Comments heard from nurses concerns a level of frustration in not being able to take care of patients adequately, lack of positive feedback and support, little respect from doctors and management and comparable pay. We need to be creative in looking for ways to keep the nurses we already have working in our facilities.

Recruitment of professional nurses is critical to many of the rural hopsitals in Oregon today. It appears that the problem is that because of a wide scope of responsibility, it is a very difficult transition for a new graduate nurse to acquire the degree of orientation needed in order for her to accept the responsibility of a registered nurse. Once again a preceptor program would furnish the needed support,

but one needs the manpower plus a certain amount of capital for the program to be successful. Also it becomes apparent that isolated areas do not offer the best incentives for the professional nurse to establish a residence, let alone have the opportunity of employment for a spouse to ensure the stability of the family unit. It is apparent that some of the smaller communities are having economic problems within their own structure and therefore cannot offer sufficient employment opportunities for incoming population.

It appears that we need to address the problem of education, retention and recruitment of nurses to rural hospitals in order to continue to provide the quality of care now being delivered by rural hospitals to the members of their communities. It is imperative to the rural communities that in most instances the rural hospital survives. If that vital link of delivering healthcare to the community dies, so shall the rural community.

What we do have going for us is that most nurses out there do care deeply about delivering quality care to their patients. These nurses are keeping patients alive every day. Their contributions may go unheralded, but the healthcare system would be lost without them.

Yes, rural hospitals do need nurses and we need to solve the problem now.

Thank you.

Respectfully submitted,

Kathleen B Mallory

Kathleen B. Mallory, RN, CNA
Director of Nursing
Harney County Hospital

August 5, 1988

KBM:sbh

BAKER CLINIC
PHYSICIANS & SURGEONS
ROUTE 1 - BOX 2-A
BAKER, OREGON 97814

MENZIE McKIM M.D.
ROBERT McKIM M.D.
JON E. PETTERSON M.D.

Congressman Wyden,

My mind reels with all I'd like to say. I've tried for hours to find a way to put an attention message together. If you have any questions during my presentation, or would like clarification, please stop me at any time.

Why do people move to and from an area? There are many reasons, but among them are jobs, the environment, schools and health care.

Rural physicians are retiring, moving, or are frustrated with their jobs and are not being replaced. Few or none of the recent Oregon Medical School Health Care graduates have moved to non-urban areas. Why?

I would tell of some of my own experiences. For continuing medical education I'm required to get 150 hours every 3 years. To obtain this I must travel to Portland, Seattle, or Boise, not just across town. My liability insurance costs the same as any other similar physician in Oregon and you have already heard of these concerns. You've also heard of the urban/rural differential in reimbursement. In my own practice I've had a partner who prematurely quit because of the frustrations of practice, mostly in the area of bureaucracy. I am in an active, long standing practice that has been in existance of over 50 years. But, because of liability insurances, decreased reimbursement, increasing paper work, and regulation is now of marginal viability.

I would like to use my obstetrical practice to explain this. I feel I'm qualified with over 22 years of experience and over 1800 deliveries. In the past I would deliver between 80 and 100 babies per year at a cost of $300.00 to $350.00. I enjoyed it very much and I also made some dollars doing this. I am now limited to 30 to 40 deliveries per year at a cost of over $1000.00 each. It is very frustrating and it is on a break even or probably even money proposition. I continue to deliver babies, however, because of a feeling of community and hospital needs. I also feel that this is part of total family care. With the invasion of the federal government and insurances in health care, the administrative costs of this care is now in the 50% area of total medical costs. These administrative costs are without any accountability. I would suggest that an evaluation of health care costs be divided into clinical care costs and the costs of administration.

As most people here, I love this area, this community, and these people. I enjoy my work and feel I do a good job. I accept the responsibilities to professional isolation, to travel for continuing education, and the long hours. Speaking for myself, for Baker, and probably rural America, we are in trouble. Without doctors there will be no hospitals, without hospitals the community will die. Few people will move to or stay in an area without a hospital.

Are you comfortable in supporting these concerns in Washington, D.C.? If not, what more can we do?

Thank you,

Robert M. McKim, M.D.